Reasoning from cause to effect: The government and the marketing of new medicine in the 80s

Michael Stanley Goryan
REASONING FROM CAUSE TO EFFECT: THE GOVERNMENT AND
THE MARKETING OF NEW MEDICINE IN THE 80s

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
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Master of Arts
in
Special Major

by
Michael Stanley Goryan
November, 1987
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Nov. 25, 1987
Abstract

Legislation passed 52 years ago still has an impact today. In 1935, Congress passed the Social Security Act which provided health care for needy mothers and children. In this spirit of providing, Congress passed a series of health care bills. Two such bills, one passed in 1965 and one passed in 1982, have changed the delivery of health care and provided sweeping changes in the health care industry.

In 1965, Congress passed Title 18, an amendment to the 1935 bill, which provided health care dollars to the nation's elderly. Attached to that bill was a provision for the nation's poor. Medicare for the elderly and Medicaid for the poor began providing both groups with health care. The costs for providing this care was more than Congress anticipated.

Passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982 placed reimbursement limitations on the health care bills hospitals were issuing to the elderly. It also restricted how long a Medicare patient could stay hospitalized. TEFRA began saving federal dollars, but hospitals began losing money and patients. Federal deregulation of the health care industry created competition among health care providers. Patients were taking full advantage of cheaper care in out-patient settings and hospital occupancy rates began to fall.

Hospital administrators thought the best way to attract patients was to advertise. Unfortunately, an investment of hundreds of thousands of dollars in advertising did not change the downward trend of hospital occupancy rates. Now, however, some hospitals are looking at marketing instead of advertising to change those trends because marketing is not advertising.
Dedication

On May 5, 1987, I lost my good friend and neighbor Raymond W. Allen. He was but 25 years of age. He will be missed by all who knew him as his wit, intellect and goodness acted as a source of inspiration. I dedicate this thesis to Ray. Thank you for being my friend.
Acknowledgements

Assembling a document of this nature admittedly took longer than I anticipated. Maybe it was naive thinking on my part, but I thought I would finish this in three months! I have since discovered a few gray hairs of "wisdom." This thesis began in July, 1986 and was completed in mid-April, 1987, at least, completed and readied for inspection. There are many people to acknowledge, but foremost is my wife Judy. Her love and support (no, not nagging) afforded me the dedication of time and space to complete this project. Without her, this thesis would not exist.

I must also acknowledge several of my professors at Cal State University, San Bernardino: Dr. Nabil Razzouk, Howard Dretel, Dr. Bruce Golden, Dr. John Kaufman, and of course, Dr. Fred Jandt. Dr. Jandt has been a continuous source of support and of information. Thank you Dr. Jandt for Service America and your Dalton interview notes.

I wish to acknowledge Rose Theiss at the Press-Enterprise for her information and input. Lastly, I would like to acknowledge the staff of Parkview Community Hospital's Intensive Care Unit, of which I was a part. Thanks for making my last days there enjoyable albeit (too) busy.
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Chapter One Introduction

Chapter Preview

There are six divisions or chapters in this thesis with each addressing a different topic. A brief overview of each chapter is presented below:

Chapter One: This chapter provides a general description of thesis content, including a description of the problem, questions to be explored, answers to those questions, thesis limitations, the importance of this study, and some of the methodology used to arrive at conclusions.

Chapter Two: Chapter two looks at California’s health care environment and traces past and present trends of the state’s Medicaid (Medi-Cal) system. This chapter also compares two community hospitals in Riverside, the eleventh largest city in California. The comparison explores many of the national trends and national legislation that has affected hospitals.

Chapter Three: In this chapter, the health care industry is explored with the problems, challenges, and reactions to the current environment. Also detailed are the advertising notions hospitals generally use when placing ads and the effects those ads have on consumers.

Chapter Four: This chapter outlines the methods by which hospital advertising is scrutinized. The chapter includes analysis of the advertising used by the two community hospitals in Riverside mentioned in chapter two. The analysis comes after an outlining of marketing techniques.

Chapter Five: Mainly historical, this chapter maps the “roots” of governmental involvement in health care and amplifies the terms, technical data, and environment used in this study. It also looks at the causes and the effects of the current health care trend.

Chapter Six: The last and concluding chapter presents what direction hospitals should be traveling. Also, this chapter looks at the two Riverside hospitals, California’s health care future, and
health care across the nation.

Finally some terms or concepts which the reader may need to know for a better understanding of the text. As noted above, a more detailed description of these terms is provided in the historical setting of chapter five.

**Outpatient:** Any service or treatment provided to a patient which involves a non-hospital stay or the utilization of a medical service away from or outside a hospital setting.

**Medicare:** National health insurance for U.S. citizens over the age of 62.

**Medicaid:** National health insurance administered at the state level for the poor or needy.

**Medi-Cal:** California's version of Medicaid (see above).

**Reimbursement:** The actual dollar amount a hospital or doctor receives for services rendered.

**Length-of-stay:** The number of hospital days a patient is allowed to utilize during an illness requiring hospitalization. A length-of-stay (LOS) is often the criteria used by Medicare, Medicaid and some insurance companies to measure payment to a health care provider.

**HMO:** Or health maintenance organization(s). An HMO is a group of doctors, paid a set fee by an insurance company, to care for those insured under a specific plan. The emphasis in an HMO is health maintenance not on hospitalization. Prevention and treatment are its concerns.

**PPO:** Or Preferred Provider Organization(s). A preferred provider is the hospital or agent of choice selected by an insurance company to provide medical care to the insured party.

**PSRO:** Or Professional Standards Review Organization. PSRO was the idea of Congress to assist in reducing unnecessary hospitalizations and/
or in reducing the number of days a patient stayed hospitalized. PSRO has since evolved into PRO or "Peer Review Organization."

**DRGs:** Or diagnosis related group. A DRG is a payment criteria Medicare officials use to reimburse hospitals for services provided to a hospitalized Medicare patient. A DRG categorizes an illness and then, based on national averages, places a payment limit and length-of-stay limit on the patient. If a hospital discharges a patient prior to the maximum number of days allotted, the hospitals makes a profit. A discharge past that maximum day limit equals lost hospital income.

**Senior Health Plans:** An insurance plan for the elderly now being used by Medicare to save the government money. Enrollees into these plans surrender their Medicare benefits to an existing insurance company (usually an HMO) in return for care without paying deductibles or premiums.

**AIDS:** Or Acquired Immune Deficiency Syndrome. AIDS patients, those infected with this deadly virus, are becoming a national concern. The majority of AIDS patients are indigent (having no insurance coverage and little or no money in which to pay for care). Hospitals giving care to a growing number of these patients face dollar losses of unbelievable proportions.
"Reasoning from Cause to Effect: The Government and the Marketing of New Medicine in the 80s" attempts to find why (the cause) hospitals have begun to advertise (the effect). For 1986 alone, hospitals put $1.1-billion worth of advertising in magazines and newspapers; on billboards and buses; in train stations and; on television and radio. Hospitals, once "sacred cows," are now finding it necessary to attract patients--business--in order to stay open. Hospitals can no longer wait for business to pour through always open doors, but instead must now go out and bring patients in. That doesn't mean hospitals are staging auto accidents or poisoning the water systems. It does mean, however hospitals are presenting educational programs to the community, giving away literature, presenting seminars--all in an effort to promote "name recognition" and hospital familiarity.

The causes for hospitals changing direction are numerous, but can best be boiled down to a handful of factors: legislation, money, competition, consumer awareness, and ignorance.

Legislation

Unfortunately, Congress, presidents, governors, legislators et al have passed numerous bills, cast numerous votes and committed numerous errors in judgment or, at least, made numerous errors in calculations. Each attempt at providing health care for groups in need--the poor, the elderly, children--has helped those groups in need, but has not always helped those entities providing that care and these attempts at providing care have certainly not
always helped those principalities having to "foot the bill," so to speak.

Legislative bills are paying the bills (see graph below), the bills of those taking full advantage of government-sponsored health care, which brings us to money.

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Act</td>
<td>1935</td>
<td>Provided federal monies for care of needy mothers and children</td>
</tr>
<tr>
<td>Emergency Maternal and Infant Care Act</td>
<td>1943</td>
<td>Health insurance for wives and children of low-ranking servicemen</td>
</tr>
<tr>
<td>Hill-Burton Act</td>
<td>1948</td>
<td>Federal construction funds for hospitals providing health care to the poor</td>
</tr>
<tr>
<td>Amendment to the Social Security Act</td>
<td>1950</td>
<td>Federal funds given to state agencies providing health care to the elderly</td>
</tr>
<tr>
<td>Title 18 of Social Security Act--Medicare/Medicaid</td>
<td>1965</td>
<td>Federal and state provisions for health care to the aged and disabled</td>
</tr>
<tr>
<td>Health Manpower Act</td>
<td>1971</td>
<td>Federal grants for medical students and relaxation of immigration laws allowing foreign medical school graduates into the U.S.</td>
</tr>
<tr>
<td>Professional Standards Review Organization</td>
<td>1972</td>
<td>Federal agency evaluating hospital admissions/care of Medicare patients</td>
</tr>
<tr>
<td>Health Maintenance Act</td>
<td>1973</td>
<td>Federal funds for the establishment of low-cost health care organizations</td>
</tr>
<tr>
<td>Certificate of Need</td>
<td>1974</td>
<td>Hospitals had to justify and receive permission to expand</td>
</tr>
<tr>
<td>Tax Equity and Fiscal Responsibility Act</td>
<td>1982</td>
<td>Revised Medicare reimbursement system based on diagnoses; DRGs</td>
</tr>
</tbody>
</table>

As each legislative measure is passed, a dip into the till results. Now, local, state, and national leaders are beginning to see the bottom of the till and are realizing reaching that bottom is easier than a few years ago. Locally, many counties are finding county hospital budgets rapidly dwindling because of cutbacks at the state level. The states are finding state budgets rapidly dwindling because of cutbacks at the national level and, in Washington, D. C., lawmakers are finding deficits in all budgeted areas of
health care—Medicare (health care for the elderly) and Medicaid (health care for the poor). All those cutbacks have had a direct effect upon hospitals. Hospitals have entered the business world and are now competing against each other for patient business.

**Competition**

A 1982 federal deregulation, affirmed by the Supreme Court (see page 39), opened the competitive floodgate among hospitals (and doctors, dentists, et al). The competition was not realized immediately, but when government cutbacks began hurting hospitals, the competition got hot in a hurry. Hospitals began "bidding" for patients by negotiating insurance and health provider contracts. Once a contract was secured, those individuals covered under that insurance plan were obliged to get their care with the contracted hospital or else pay most of the bill themselves. Understandably, the hospital with the most contracts is the "winner." That is one form of the competition. Another form is that of gaining consumer awareness.

Consumer awareness has two sides: perception and education. Consumer perception has much to do with image. What image does the "typical" consumer have of the area's hospitals? Would this image keep an individual away from the hospital or would it attract a patient? Consumer education deals with the "new" consumer, the consumer more interested in staying healthy, working out, eating right, wishing to be more knowledgeable about disease and health. To face this "new and informed" consumer, hospitals have started various programs—"wellness programs"—to attract potential patients to a certain hospital. The more and better the programs,
the more name recognition is promoted within the consumer and, should hospital treatment ever become necessary, the greater the possibility of that consumer utilizing the hospital that "cared" enough to sponsor the program. At least, that's the theory. To attract patients to these programs and to many of the other hospital-provided services, advertising has been employed. Hospitals are advertising community programs, but the advertising is not limited to just those programs. The media have become filled with other messages: "We are the best;" "Our hospital is better;" "Call this number for a doctor;" "For all your health care needs."

Hospitals do all this advertising because of the competition and because the health care industry believes it has to do something. Unfortunately for the industry and for the consumer, advertising increases the cost of health care. Someone pays the $1.1-billion. An even sadder part of hospital advertising is most of the individuals responsible for creating and placing the ads are ignorant of basic advertising and marketing principles.

Ignorance

Ignorance has cost hospitals hundreds of thousands of dollars. The fault, however, does not lie completely with those individuals formulating the ads. Much of the cost and blame belongs with hospital administrators. Their ignorance of advertising principles has cost their own hospital and patients a neat bag of change.

This thesis looks at hospitals. The nation's hospitals are experiencing problems because of legislation; problems because of money woes; problems due to competition and to consumer awareness and; finally, problems due to
ignorance. This thesis also explores the causes and the effects as to why the hospital industry believes advertising is the key to survival. This study presents criteria hospitals should be using in order to effectively communicate to a hospital's service area and how best to market services, not just advertise services. This study points out the differences between marketing and advertising.

This thesis has some limitations, one which is unavoidable: the newness of healthcare marketing. The problem is new and, therefore not all the theories of "how to do it" have yet surfaced. Another limitation, probably the more important one, is that of predicting the future. The future of health care is cloudy and attempting to part those clouds with some profundity is difficult at best. There are many factors keeping these clouds hovering around the answers: government unpredictability, which includes national, state and local responses to crises; conglomerate takeovers of smaller, less financially stable hospitals; hospital reaction to the growing competitive environment and; the growing problem of indigent patients.

These problems cut across all segments of society and should be of concern to all who will, at sometime, need hospital care. When that need arises, what will one find when entering a hospital or will the neighborhood hospital be there when the need for hospital care is evident? "Marketing of New Medicine" has to do with business and marketing, not often the most readable or interesting subject, however this study deals with what hospitals see as the method of solving new problems and surviving. Marketing for survival is the future for health care.

Further, "Reasoning from Cause to Effect: The Government and the
Marketing of New Medicine in the 80s' asks:

1. How the government got involved and why?
2. Why the government is now trying to get uninvolved?
3. How and why hospitals are reacting to the environment?
4. Why hospital censuses have drastically decreased?
5. What effect AIDS is having and will have upon hospitals?
6. Why advertising is the sought form of relief?
7. What is the difference between advertising and marketing?
8. What affect is advertising having upon the consumer?
9. Where are hospitals going right and going wrong?
10. What does the future hold for hospitals?

Attempts at answering these questions include documentation of past and present governmental involvement; presentation of what environment hospitals are now facing; a look at a series of items causing further declines in hospital censuses; a look at what factors have hurt hospitals most; a brief historical presentation of hospital advertising; a concise outline of a marketing plan; a view from the consumers' side; a tracing of hospital direction and; an educated guess as to health care's future.
Chapter Two Introduction
California Hospitals Battle State, National Environment

California has the national reputation of being the mecca for anyone seeking perennial sunshine. In California, one can drive from beach to mountain in a couple of hours. One is healthy, rich, and of course, well tanned. However, all is not well in California. The state is experiencing budget problems and deficit spending is occurring in the state's Medi-Cal (Medicaid) system.

Medi-Cal beneficiaries use up one out of every eight tax dollars and California's governor George Deukmejian, in 1986, blue-lined the Medi-Cal budget in order to save the state some money thus hurting health care providers. Payments for service rendered have been reduced to both doctor and hospital. These reductions are causing many doctors and many hospitals to re-evaluate providing care to Medi-Cal dependent patients. Both providers have been dropping out of the Medi-Cal program, creating extra stress upon county facilities and county budgets.

In addition to the governor's action, California's legislature passed two crucial bills which mirrored many of the provisions and changes made by Congress in the Medicare system. Service restrictions, reimbursement reductions, and limits in coverage were the goals set by Congress, and California's lawmakers borrowed those goals for Medi-Cal. The similarities between the reforms in Medicare are too close to those prescribed for Medi-Cal to believe otherwise.

The table below outlines the more significant similarities between Medicare and Medi-Cal.
<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>MEDI-CAL</th>
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<tr>
<td>Runaway costs</td>
<td>Runaway costs</td>
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<tr>
<td>Legislation introduced to reduce payments to hospitals (TEFRA)</td>
<td>Legislation introduced to reduce payments to hospitals (AB 799 and AB 3480)</td>
</tr>
<tr>
<td>Government encouragement of competition among hospitals and health care providers</td>
<td>Competition demanded among hospitals to &quot;bid&quot; for Medi-cal contracts</td>
</tr>
<tr>
<td>Reduced reimbursement rates via diagnosis related groups</td>
<td>Reduced reimbursement rates of up to ten percent</td>
</tr>
<tr>
<td>Utilization controls</td>
<td>Tightening of utilization controls</td>
</tr>
<tr>
<td>HMO participation</td>
<td>HMO participation</td>
</tr>
</tbody>
</table>

The passage of AB 799 and AB 3480 have contributed to declines in California hospital censuses just as the Tax Equity and Fiscal Responsibility Act did when Congress passed it in 1982. The figures for California hospital occupancy rates are in the low 50 percentile, a sizeable lag behind national figures. With both Medicare and Medi-Cal restrictions to contend with, California hospitals are searching for the solution to fill both empty beds and waning bank accounts.

This chapter focuses on California's health care environment and will examine the response of two community hospitals in Riverside, California. Riverside was selected, in part, for its proximity, size, age, growth rates and its two competing community hospitals. Riverside, the eleventh largest city in California, sports a population of 192,000. Growth of 3.7 percent occurred in 1985 and, according to city estimates, grew another three percent in 1986.1
Chapter Two
California Hospitals Battle State, National Environment

The State of California was witnessing a 17.9 percent increase in hospital costs in 1981 and, faced with a $900-million budget shortage, had to cut expenditures. California also faced a potential $2-billion deficit in its Medi-Cal (Medicaid) program. The Medi-Cal program eats up one tax dollar out of every eight.\(^2\) An appeal to cut health care costs went out, but "despite voluntary efforts by the California Hospital Association and the California Medical Association to contain costs, hospital costs in California increased ... 19.8."\(^3\) In an effort to stem rising health care expenditures, in 1982, the California legislature passed provisions that "authorized both the government and private insurance companies to negotiate prepaid contracts with hospitals and providers as a 'tool' to contain costs."\(^4\)

This legislation gave the state a "consumer" attitude. Medi-Cal officials could now shop around for the best cost provider for Medi-Cal dependent patients. The legislation also had several similarities to the federal reforms of Medicare, i.e. the review process: "The bill ... contains provisions requiring tightening of utilization controls for services ... including ... those medical or surgical procedures which are capable of performance in an outpatient setting...."\(^5\) (emphasis mine) In addition to review, the bill also allowed Medi-Cal recipients to participate in health maintenance and preferred provider organizations. Cuts in Medicare follow cuts in Medi-Cal. "California has restricted program eligibility, reduced reimbursement rates by 10 percent, removed $16-million worth of drugs from the Medi-Cal formulary, mandated that $21-million be saved through strict prior-authorization requirements, ... added $1 drug co-payments, [and] reduced

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coverage of vision and hearing devices and services..."(emphasis mine)

Reductions in reimbursement rates meant less money would be received by hospitals caring for Medi-Cal patients. The Medicare bylaws, coupled with the Medi-Cal bylaws, began taking a toll on California hospitals—fewer patients and less money—but there were other surprises in store for California's hospitals. Medical was no longer going to be utilized by every hospital as more restrictions took effect. Now, "Medi-Cal patients [can only receive] their care in a few, selected California hospitals with state contracts obtained through a price-competitive bidding process. No longer can Medi-Cal patients and their doctors choose locations for medical care." Each hospital in California had to compete against its neighboring hospital for a Medi-Cal contract. A loss of the contract equaled a loss of Medi-Cal patients along with decreased revenues because of decreased censuses. This Medi-Cal contract business was a "Catch-22" situation. Hospitals saw reimbursement rates for Medi-Cal decline and wondered if caring for a Medi-Cal patient was fiscally sound, yet, no caring for these patients decreased inpatient censuses. So, hospitals got philosophical: A Medi-Cal patient brings in more money than an empty bed. With that philosophy, many hospitals entered the bidding wars, but unfortunately only one area hospital can land a contract.

**Occupancy Rates Dip Below National Average**

The 1982 Assembly bills AB 799 and AB 3480 contributed to California’s decline in hospital in-patient business. In fact, California hospitals dropped below the national in-patient average. Nationally, hospital
occupancy rates are between 66 percent\textsuperscript{8} and 75 percent.\textsuperscript{9} California's average occupancy rate, according to Jill Zapp, Director of Planning for the Hospital Council of Southern California, "has fallen into the low 50 percentile."\textsuperscript{10} Her numbers were verified by Dave Hecomovich, Health Planner for the Office of State-wide Health Planning and Development. He outlined these occupancy rates: 1981, 61.3 percent; 1982, 59.6 percent; 1983, 58.1 percent; 1984, 54.9 percent and; 1985, 53.6 percent.\textsuperscript{11}

For 1986, although no current figures are available, Hecomovich predicts the current trend of slumping occupancy rates will continue. "There are fewer patient days and general acute care stays are falling off," he said. Zapp, however, does not agree with the further decline. In a telephone interview, she said, "The declines are slowly creeping back up albeit at a minimal percentage." She points to sicker patients staying longer periods and for out-patient services to "max out" in the very near future.\textsuperscript{12} Hecomovich referred to an increase in specialty hospitals taking patients away from established general acute care facilities, and Zapp echoed some of the same sentiments when she talked about AIDS patients. "Similar to what the nation did for TB patients, states with high numbers of AIDS patients may begin establishing specialty hospitals, or privately-owned specialty hospitals will pick up the slack and possibly bid for contracts from HMOs, private insurance firms or the state (Medicaid) to take care of AIDS patients. If, however, private insurance firms begin denying coverage for AIDS patients, the burden will fall at the state or at the local levels."\textsuperscript{13}

A privately-owned hospital in Houston, Institute for Immunological Disorders, recently opened and is considered the world's first hospital
exclusively for AIDS patients, however it is losing up to $800,000 a month because 40 percent of the hospital’s patients are indigent. The purpose is noble but fast becoming very expensive for its parent company, American Medical International. Patients are being referred to the hospital by 28 states and three other nations.

The real fear among California’s lawmakers is that AIDS victims will deplete state Medi-Cal monies and other truly needy patients may not receive coverage because of low or exhausted budgets. This fear may come to pass as the newly-discovered anti-AIDS drug, AZT, “was made available . . . to eligible Medi-Cal patients.” The estimated cost for the upcoming fiscal year (7-87) is $7.5 million with an even higher expenditure predicted for 1988.

County and local hospitals may experience a severe financial burden by caring for AIDS patients. "County hospitals will find their dollars used up and local hospitals may be forced to care for indigent adult AIDS patients. Reimbursement will be at a minimal rate and hospitals will lose money.”

California Regulations Place Hospitals at Greater Risk

"Hospitals in California are generally at greater risk [of closure] than those in the nation as a whole,” stated a recent poll among California hospitals. "California hospitals suffer in the complicated Medicare payment system . . . [and] incur higher operating costs . . . for several reasons, including more stringent building codes, higher pay levels, and higher standards of care.” California’s hospitals have Medicare and now Medi-Cal dilemmas.

As the nation’s hospitals swim upstream amidst competition and federal
regulations, California's hospitals must learn to "sink or swim." Competition for patients and competition for Medi-Cal dollars increases as the occupancy rate decreases. "Small community hospitals have probably been hardest hit by the growing competition."\(^{21}\)

The administrator at Riverside Community Hospital declined the opportunity to be interviewed for this study stating: "There is too much competition between the two hospitals and I feel uncomfortable answering questions."\(^{22}\) Health care competition is a reality in Riverside, California.

The largest of the two community hospitals, Riverside Community Hospital (hereafter referred to as "Community") is located in Riverside's downtown sector. It originated in 1903 with 30 beds. Riverside was 20 years old and the city had but 9,000 people. It started as a for-profit hospital but, 17 years later, changed its status to non-profit. After relocation and expansion, Community now totals 445 beds.

Community is considering the creation of its own health maintenance organization (HMO) in efforts to attract patients and, with attracting patients in mind, it joined a national HMO--Voluntary Hospitals of America--to widen the hospital's base of influence. Voluntary Hospitals of America (VHA), along with Aetna Life and Casualty co-own Partners National Health Plans. VHA's and Aetna's "Partners" offers PPO and HMO products throughout the USA. VHA-affiliated hospitals number over 700 and currently account for 20 percent of all acute care hospital revenue in the country.\(^{23}\)

Community has numerous other HMO and PPO contracts and, according to Steve Hartert, marketing and publications coordinator, "competes hard for lucrative HMO contracts."\(^{24}\)
Parkview Community Hospital (hereafter referred to as "Parkview") opened on November 4, 1958 with 48 beds. The growing City of Riverside had a population of 79,000. Parkview's last expansion put its total bed capacity at 156. It does not have its own HMO but, instead has several HMO and PPO contracts including Kaiser and recently landed a one-year Medi-Cal contract.

These two hospitals have not been exempt from the changing health care environment.

PSRO

The Professional Standards Review Organization (PSRO) program originated in 1972, one of Congress' attempts to cut Medicare and Medicaid flow of dollars. PSRO succeeded in decreasing some unnecessary hospital admissions and decreasing patient days. However, in its infancy, PSRO did little to stop the over-utilization of services by physicians. A few years ago, PSRO evolved into the Peer Review Organization or PRO. PRO established a review process of physicians by physicians. Some power has been infused into PRO which now has enforcement capabilities attached to penalties (some of those penalties involve dollar amounts which may ultimately hurt physicians who abuse medical services). California Medical Review, Inc. pays a local, in-hospital physician to monitor possible services overload by peer physicians. That paid physician contacts the physician in question and asks for justification of treatment. If that explanation does not satisfy the reviewing MD, the case goes to California Medical Review, Inc. and payment for treatment is withheld pending a decision.
Community established a one-person PSRO program in 1971 calling it the Utilization Review Department. Ten years later, Utilization Review had evolved into Quality Assessment and the staff grew to seven. During an interview with Gillian Hart, director of Quality Assurance at Community, she said, "Peer review has, through sanctions, the power to stop or at least decrease over-utilization of services by doctors."

Parkview's Professional Standards Review Organization began in 1984 with one staff member. In 1986, the department grew to three staff members and was renamed Utilization Review. According to Betty Petty, utilization review coordinator at Parkview, her department also has power to stop over-utilization of services by physicians. "If it is determined the service was medically unnecessary, PRO (Peer Review Organization) can withhold payment until the physician justifies treatment."

Does PRO decrease hospital revenues? Does it save hospitals money? According to Hart, the answer is no on both counts, but Petty has different thoughts on the subject.

"Peer review is an effective tool for saving Parkview money," she said. "We identify a prospective denial [of money] before it happens and suggest alternate ways of caring for the patient--out-patient services, board and care or nursing homes." Petty also said Parkview has implemented a "medical short stay" program which does not admit a patient, but will observe an "iffy" admission patient for 24 hours and then make a determination regarding admission. One Parkview physician calls that practice "ADRGs," or "Around Diagnosis Related Groups," the criteria used by Medicare in determining payment, measuring Medicare patient days in the hospital, and
neccesity of treatment.

These diagnosis related groups or DRGs, has effected both Community and Parkview and hospitals across the nation. DRGs are being blamed for premature discharges of patients, many, it is believed, still in need of acute care (see page 82). Hart at Community does not believe the DRG reimbursement system has decreased the lengths-of-stay for Medicare patients but Petty does. "Many procedures previously done within the hospital are being performed outside the hospital--out-patient services. Hospitals are making great efforts to place patients in lower levels of care facilities."

Lower levels of care does not automatically equate to less quality of care. For instance, a patient needing intensive care five years ago, would stay up to 10 days. Today, the figure is three to four days. Actual numbers for Parkview’s intensive care from the period of March '81 to November '81 were 2.75 days per ICU stay with some months averaging over four days per ICU stay. Statistics for March '86 through November '86 were 2.12 days with some months showing average stays below two days.

The claims that DRGs are hurting the Medicare-dependent elderly are denied by Hart and Petty. "What DRGs are saying to hospitals is 'If this patient can be treated at a lower level of care (i.e., convalescent) then that’s where the patient should be,'" Petty said. "Since the government is paying the bill, it has a say so in the treatment of the patient."

The recently retired president of Arlington Health Services (Parkview’s parent company) Dr. J. Dee Lansing, stated regarding DRGs:

"DRGs do decrease the lengths-of-stay of patients, but we (the
hospital) were expecting that. I believe the system of reimbursement is better managed than the old system but this new payment system has had more of an impact than previous reimbursement programs.”

Lansing, founder of Parkview Community Hospital, also said, “Government will continue to cut back its health care expenditures be it with DRGs or some other program. We [the hospital] must continue to face each cutback.”

Community’s Hartert said, “DRGs hurt all hospitals and ours are no exception. We have had to target areas for cost containment and review each program.”

There is thought in Congress of imposing a five-year freeze upon DRG reimbursement rates. Should this five-year freeze take effect, both Lansing and Hartert agree, maintaining the facilities and purchasing new equipment would be difficult. Lansing said, “It could put us out of business.”

HMOs

A Health Maintenance Organization or HMO is a group of doctors, paid a set fee by an insurance company, to care for those insured under a specific plan. The emphasis in an HMO is health main-tenance not hospitalization. Prevention and treatment are its concerns. If patients are hospitalized, HMO profits are decreased. (For more details regarding HMOs, see pages 88-91.) HMO patients are restricted to use hospitals that have negotiated a contract with the governing HMO.

The largest Health Maintenance Organization in California is Kaiser with
approximately 75 percent of all HMO enrollees in the state.

The Riverside area does not have a Kaiser hospital although one is under construction. The next closest facility, located in Fontana, is a twenty-five minute drive from Riverside. The Riverside Kaiser construction is scheduled for completion in September, 1988, but questions of funding may delay that opening until later in the year or the early part of 1989. The administrators at Parkview hope for that delay.

Parkview landed a Kaiser contract in early 1986. Kaiser patients represent approximately 20 to 33 percent of Parkview's total census. A September '88 opening for the Riverside Kaiser hospital would equal a large, unavoidable decrease in Parkview's census.

Both hospitals bid or negotiate for HMO contracts. Reimbursement for services usually stands at between 70 to 80 percent. There are several HMOs in Riverside, too numerous to list, but a partial list would include Kaiser, Cigna, PacifiCare, MaxiCare, Inland Health, Health Net, FHP, and Inter Valley Health. HMOs have not cornered the market when it comes to negotiated contracts with hospitals; private insurance firms have joined in.

The majority of insurance firms, from Blue Cross to Wausau, negotiate contracts with hospitals so policy holders have the convenience of a local hospital and doctor and the insurance company has reduced reimbursement expenditures. Both Parkview and Community hold HMO and Preferred Provider Organization (PPO) contracts. Even with a discounted reimbursement schedule, "it's better than having an empty bed," Lansing said, "but HMOs drive hard bargains which usually equates to a decrease in [hospital] profits."41
creasing services and lengths-of-stay for enrolled patients," said Gillian Hart at Community, "but the hospital does not treat HMO patients with less care or with less quality of care."45 A length-of-stay does not carry the weight it used to for both Medicare patients and HMO patients," Petty said. "We [Parkview] now evaluate patients by severity and intensity of illness although some companies will authorize days for stay and, if more days are needed, another review is done to receive that authorization."46

Because HMOs prosper if hospitalizations are avoided and hospital stays are shortened, HMOs, much like Medicare's DRGs, encourage early or premature discharges, at least HMO critics claim that is true. Are HMO patients being discharged sooner and sicker than they should be? "Yes," said Hart. "Some insurance plans are more aggressive."47 But Petty disagrees. "Discharge criteria must be met before patients are released. If a patient is released prematurely, we are at risk."48

With the Tax Equity and Fiscal Responsibility Act (TEFRA, see pages 79 and 80), passed in 1982, HMOs took on a certain importance to the government and to Medicare beneficiaries. The elderly, Medicare-dependent individual can now join an HMO. The debate of 15 years ago--"HMOs operate according to economic incentives that encourage under-use . . . [and] (HMOs) might neglect the many medical needs of the elderly and seek to enroll only healthy persons in the 65-and-over population--"49 remains today's debate. Judy Goryan, admitting manager at Parkview, said: "Many HMO plans for Medicare patients seek out the less sickly patients and encourage the enrollment of healthy seniors thus neglecting those who may cause the HMO to lose revenues."50 In the January, 1985 New England Journal of Medicine.
Secretary of Health Margaret Heckler said, HMOs "mean more complete medical coverage with lower out-of-pocket costs" for the elderly and for the government. Lower costs, lower quality?

When a Medicare beneficiary joins an HMO i.e., Secure Horizons or the Inland Senior Health Plan, the individual surrenders his or her Medicare rights on a month-to-month basis according to Goryan. "Medicare patients, enrolled in an HMO, no longer come under DRGs, the government form of reimbursement, but instead come under capitation. Capitation money is given to the hospital for an admitted, eligible HMO senior. If costs for a fixed time period are less than the pre-set capitation payment, the hospital pockets the money. If hospital services exceed capitation, the hospital loses money."52

The hospital is not the only entity to lose money. Health Plan of America (HPA), a Southern California-based HMO dropped its Medicare-enrolled patients because "of financial losses," said Eleanor Brewer, vice president of HPA. "The flat fees paid to the HMO by Medicare were insufficient to cover beneficiaries needs."53 Brewer also stated an Illinois-based HMO lost $4-million in six months for the same reason.54 Despite these two examples, HMOs are still scrambling to enroll Medicare beneficiaries. Secure Horizons uses TV star Lorne Greene in its television advertisements to enlist patients. The enlisting of patients is working for the majority of HMOs.

"Since the elderly are usually on fixed incomes, most patients prefer this form of medical care which does not require any further outlays of money," said Petty, "and that is the most appealing facet of an HMO for
seniors. Plus, HMOs are offering patients "one-stop shopping" i.e. "preventive services, eyeglasses, hearing aids, prescription drugs with about a $1 co-payment, and dental services. Those who enroll accept the requirement that they must receive all their care through the HMO."

The government likes HMOs because "HMOs have shown remarkable results in reducing hospitalization rates by as much as two-thirds with resultant cost savings," said Dr. T. Franklin Williams, director of the National Institute on Aging. Many HMO subscribers are directed to out-patient facilities rather than to hospitals.

Out-patient Services and Competition

Out-patient facilities continue to proliferate. Urgent care centers and free-standing emergency centers ("Doc-in-the-Box," "7-11 Medicine"), and surgicenters ("M*A*S*H meets McDonald's,"') have added to the growing number of hospital problems. These independent-from-hospital businesses are contributing to the decrease of hospital use, but hospitals are beginning to fight these out-patient facilities.

Several years ago, Community purchased Knollwood Hospital, a small, privately-owned facility, and turned into an out-patient drug and alcohol rehabilitation center. Now known as the Knollwood Center, it is being used to perform some out-patient surgery. The hospital does not realize any real competition coming from urgent care centers.

"Urgent care centers are really providing competition to the physicians and not to the hospitals," said Dalton. "In fact, many urgent care centers are located very close to emergency rooms and build the volume in emergency
If [urgent care centers] are successful and handling high volumes of patients, a certain percentage of those become hospitalized or use [hospital-based] out-patient services. Dalton believes surgery centers have hurt Community: "Well-organized groups of physicians have been able to control enough of a volume to make [a surgery center] cost-effective and have, indeed, taken away some... revenues," Dalton said. "Many hospitals have created a joint-venture with physicians and are splitting the dollars." Dalton may be referring to what Parkview has been doing.

Parkview has financed several clinics and assisted in the establishment of several physicians offices, plus it has three out-patient facilities all housed across the street from the main hospital. These services are an occupational medical center with x-ray and pharmacological services. In early 1987, Parkview purchased a medical and dental clinic in the Riverside suburb of Jurupa; purchased the Family Birthing Center from a group of physicians; purchased the Riverside Surgery Center (an enterprise once affiliated with Community) and; expanded its own in-house ambulatory surgical center.

The moves by Parkview to focus on out-patient services is more cost-efficient and, according to E. Romayne Chinnock, Parkview's vice president of marketing and public relations, are "to take services... to the citizens rather than expect everyone to come to Parkview." What is difficult to understand about the acquisition of the Birthing and Surgery Centers is that these two facilities are located just a few blocks from Parkview and that's hardly "going into the community." Plus, these two facilities were rumored to be losing money. Also clouding the overall picture is that Parkview has an alternate birthing room and an ambulatory surgical center located within the...
hospital. One possible explanation for the acquisitions may be in response to what Dr. Lansing said regarding out-patient clinics: "Third-party billers (insurance companies) are encouraging subscribers to take advantage of out-patient settings. They [insurance companies] would prefer an individual utilize a clinic rather than an emergency room as the costs are significantly less."^66

**Medicaid**

"Medicaid has been victim of miscalculation since its inception; no one knew enough in 1965 to predict with any accuracy how many people would be enfranchised under the program. Medicaid proponents may have provided unrealistically low estimates of cost and eligibility in order to sell the program to Congress."^67 Just two years after the enactment of Title 18, "Congress was amending Medicaid to reduce cost overruns. The medical cost component of the Consumer Price Index rose from 2.1 percent to 6.5 percent."^68 The last year the country experienced single-digit, health care price increases was 1965 (until 1984). The government’s health care tab for 1965 totaled $42-billion, or six percent of the Gross National Product.^69 Four years later, "Medicare and Medicaid had [proven] to be more costly than legislators and planners expected..."^70

Now, in 1987, President Reagan wants to slash $21.6-billion from the Medicaid program^71 in the next five years. That amount places a larger burden of responsibility upon individual states to provide more health care dollars for the poor. To place that into perspective, the federal government, in 1985, contributed $21.9-billion to the Medicaid program.^72 A cut of
$21.6-billion would severely reduce federal cash outlays. Testimony before a U.S. House of Representatives Budget Committee hearing held in Los Angeles stated: "The president's ... budget proposal is 'irresponsible and unimaginative,' would hurt both hospitals and Medicaid beneficiaries, and 'shirks the government's role in helping those most in need.'"73

**Medi-Cal**

Medi-Cal, California's version of Medicaid, which provides care for three million poor people in the state (or approximately 14 percent of the nation's poor), faces cuts, not just from the federal government, but from the state's governor. The state's overall 1985-86 fiscal budget was short $1-billion and Governor Deukmejian cut Medi-Cal payments by 10 percent which saved the state $20-million. This cut was done without approval from the state's legislature. (The California Medical Association attempted to stop the reduction but failed in the Third District Court of Appeals. The cuts were then appealed to the state's Supreme Court, but that, too failed.75) The governor wanted more cuts in the Medi-Cal budget for 1987-87 including (possible) elimination of dental care and some out-patient services; reductions in reimbursement rates and; reviews of all services to weed-out unnecessary care.76 The California legislature, angered over the proposed $300-million in cuts, voted on April 1, 1987 to restore the cuts made by the governor. The governor, however still wants the cuts according to Health and Welfare Secretary Clifford Allenby.77

Steven Merksamer, the governor's former chief of staff said in December 1986, "Medi-Cal once again needs to be reformed. It is time for
the providers, . . . the legislature and the executive branch to take a good, hard look at the Medi-Cal program.\textsuperscript{78} State democrats say the Medi-Cal program is deeply in the red this fiscal year (7-86 to 7-87).\textsuperscript{79}

"All Medicaid programs pay less than providers think is fair and, in many cases, . . . pay less than what even a cynic would call reasonable."\textsuperscript{80} "Past Medi-Cal payment cuts resulted in less physicians accepting Medi-Cal patients and, with the proposed cuts, more are expected to leave the program," said State Senator Diane Watson, D-Los Angeles.\textsuperscript{81} "[Because of decreased reimbursements to physicians], "an erosion in physician participation in the [Medicaid] program and growing physician limits on Medicaid case loads . . . has reached crisis proportions."\textsuperscript{82}

The Local Effect of Medi-Cal Cuts

Reimbursement payments to Medi-Cal facilities have caused headaches to Riverside area hospitals including Riverside General (county) Hospital and neighboring San Bernardino County Medical Center. San Bernardino County supervisors told the state the county was terminating its Medi-Cal contract "because Medi-Cal reimbursements are falling far short of the actual cost of providing treatment for elderly, blind, and poor patients."\textsuperscript{83} That falling short resulted in a loss of $4-million by San Bernardino County. To further the point of decreased reimbursement and escalating costs, California hospitals have an estimated $1.5-billion in unpaid bills "with $900-million in bad debts and charity care and $600-million in unreimbursed Medi-Cal costs."\textsuperscript{84} (emphasis mine) Nationally, bad debts and charity care cost hospitals $7.4-billion in 1985\textsuperscript{85} (meaning California hospitals have 20
percent of the nation's bad health care debts). Many hospitals currently providing large volumes of unsponsored care will be forced to choose between bankruptcy and a drastic reduction in services to the poor. Lansing said the state has one of the poorest indigent health programs with much of the costs for Medi-Cal and charity care being heaped upon third parties (insurance companies), the hospitals, and the doctors.

Testifying before a House Ways and Means subcommittee, Jack Owen, executive vice president of the American Hospital Association said, "Medicaid coverage of the poor shrank from 65 percent to 38 percent in the last decade while the number of people living below the poverty line increased." "Large cutbacks in Medicaid under the Reagan administration have forced many states to reduce the number of poor covered, thus further exacerbating the problem of uncompensated care," said Fortney Stark, chairman of a House Ways and Means subcommittee.

Of the two hospitals in this study, only Parkview has a Medi-Cal contract. With less physicians accepting Medi-Cal patients "some [patients] will wind up in Parkview's emergency room," said Kenneth Willes, Parkview's administrator. "That will drive up our charity work . . . [as] Medi-Cal covers, at most, 30 percent of the costs of emergency room care." In-patient payments are not supposed to be affected but out-patient services such as ambulatory surgery and physical therapy will be.

Parkview is located a few miles from the county's hospital and, as a result, was receiving Medi-Cal patients anyway, but had to get treatment authorization from the state and had to transport all non-critical patients to the county facility once a bed was available. Critical patients had to be
stabilized first then moved. Said Willes on negotiating a Medi-Cal contract, "Our beds, empty or filled with Medi-Cal patients, costs us the same amount of money. We might as well get something for having the bed available."92

There can be a problem with that philosophy, however. Emily Friedman reports in Hospitals magazine: "A bed with a low-paying patient in it is still more remunerative than an empty bed, but when and if, hospital capacity declines and beds are more at a premium, the Medicaid patient will not be able to compete with other, better-paying patients."93

Parkview's ultimate hope is, once Kaiser opens, the resultant 20 to 33 percent census decline will be replaced by Medi-Cal patients, although the reimbursement rate will be less. Parkview's Medi-Cal contract has contributed to an increase in census, but mostly in maternity services.

The avid negotiation of contracts, the acceptance of Medi-Cal, "ADRGs," out-patient services . . . all are attempts at bolstering budgets, but all of these attempts are futile, unless there is a physician admitting patients and prescribing treatments.

**Physician Services**

No doctors, no patients--a solid theory utilized by the majority of hospitals. In efforts to attract physicians and their patients, hospitals are offering practice-building services to physicians. These services come in many forms (see pages 45 and 46), but a very common service is physician referral. A physician's referral service works when a consumer calls a number, describes his or her medical needs (and often times a sickness or disease) and is then referred to a physician (which often puts a non-trained
individual in a position of diagnosing). That referred physician's office is then called by the consumer, told of the referral and given a priority appointment. The referral service only recognizes those physicians with admitting privileges at the offering facility.

Both Parkview and Community have physician referral services. Parkview's physician referral service logs about 200 calls a month but, because of a lack of tracking or follow-up, the service is, as Lansing said, "Inconclusive as yet." That inconclusive service is a couple of years old and one wonders what return on investment, if any, Parkview is realizing with this service?

Dalton said Community's referral service received over 4,000 calls in 1986. Many of those calls, according to Hartert, are from new people in the community. Dalton said 15 percent of those who placed calls and were referred ended up as in-patients or utilized Community's out-patient services within three months after placing the initial referral call. Hartert further stated, "Fifty to 60 percent of our callers follow through with contacting the referred physician. Our tracking process sends a card to the physician and a questionnaire to the caller. The response from those two organs is very good." Thus, Community has tracked approximately 2,000 to 2,400 individuals using the physician referral service and, of those, 15 percent utilize Community's in-patient or out-patient services. That equates to 300 to 360 new patients per year as a direct result of the physician referral service.

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Physician Recruitment

Again, the premise is no doctors, no patients. Hospitals across the country are searching for doctors. Parkview has no search agency but, according to Lansing, actively recruits doctors by relying upon staff physicians to do the contacting and recruiting. Considering most physicians have staff privileges at two or more hospitals, that reliance could easily backfire. Lansing also admitted a large dependency upon staff physicians to bring in new patients and, because of Parkview's smallness, that dependency demands a constant fostering.

In its attempt to create good hospital-physician relationships, Parkview, in early 1987, started a physician newsletter, which, according to one staff physician, "is ridiculous and infantile." The information contained in this newsletter is often a regurgitation of old hospital news.

Community uses advertising dollars to build physician practices who, in return, will refer patients to Community when hospitalization is necessary. Many "wellness programs" are geared toward boosting physician practices. "When we do the heart care program, when we do the family birth place, when we do physician referral... we're really trying to develop the referral base for the doctors," Dalton said.

One inherent problem with referral services is some older, more established doctors do not want any more patients. The hospital wishing to establish this service must first survey its staff physicians to learn how many doctors want referrals. Those hospitals that fail to do so often alienate those doctors with full practices.
Customer Service and Staff Training

Thus far, the word service has been attached to many areas involved in this study: out-patient services, physician services, tightening of services, utilization of services, and reimbursement for services. What is/are the service(s) hospitals are offering? To begin, a service is often an intangible or conceptual product. Health care is a service but with intangible and often undefined products. (Most hospital administrators or marketing executives do not know what specific products their facilities offer which leads to nondescript advertising as discussed in chapter four.) Health care then is intangible yet care is the service being offered to those in need of health care products. These products—beds, medicine, nurses, therapy, visits from the physicians, tests, etc.—are exclusive to the health care industry. Other health care products can be insurance; medical equipment i.e., wheelchairs or crutches; or prescribed and over-the-counter drugs.

The health care industry has been described as "the most intimate of human services" where "living and dying are its unique stakes."101 (emphasis mine) Is life health care's service or services? To elevate that thought to a more tangible one, health care's services can be viewed as customer relationship with the customer (patient) representing the consumer of a product. That tangible concept is the new thinking needed by service industries if, in this new age of product management and product differentiation, a company, business or industry is to survive. Unfortunately, that service concept has not yet been fully grasped by the health care industry. Those few hospitals which have accepted and adapted to the changing nature of business will survive the crises besetting the health care
industry. Those hospitals clinging to the ideas that "everyone needs us" will find just the opposite. People tend to repeat their business at a place which treated them, the customer, as a person.

Drawing from the book Service America: Doing Business in the New Economy by Karl Albrecht and Ron Zemke:

"The trend toward consumerism, the changing competitive climate, and the recent recession... have forced companies to reexamine... relationships with customers. As a result, customer service has become a strategic tool. It used to be regarded as an expense. Now it is seen as a positive force for increasing sales--and for reducing the cost of sales." (emphasis mine)102

Albrecht and Zemke state, regarding service, "It is the competitive edge. People buy expectations... the benefits the seller promised."103 What benefits, expectations--services, if you will--do hospitals offer?

According to Lansing, Parkview is in the "acute care business" which offers surgery, pediatrics, pharmacy, intensive care et al, as "its products."104 Dalton quoted Community's mission statement and summarized its business as "providing the community with wellness... through either education and prevention or treatment."105 Both Lansing and Dalton skirt the true issue of treating the patient as the customer although Dalton said Community had a "guest relations" plan on the drawing board.106 He identified certain areas of the hospital in need of targeted and selected programs in guest relations with maternity being the first of such targeted areas because of patient and visitor complaints regarding the "rigidity of the maternity nurses."
Acquired Immune Deficiency Syndrome—AIDS

Riverside County is preparing for an onslaught of 2,400 AIDS cases over the next four years. This could, say some authorities, "force the closure of Riverside General Hospital (the county hospital) -- even bankrupt the county." Riverside County Supervisor Norton A. Younglove said AIDS expenditures could equal "the county's current half-billion-dollar annual budget [and] this may add up to bankruptcy before the year 2000."  

The Riverside Press-Enterprise, the local newspaper, cited a recent state survey that demonstrated this very startling statistic: "Southern California hospitals (Parkview and Community included) lose an average of $5,214 in revenues for each AIDS patient." Steven Larsen, a Riverside doctor specializing in infectious diseases, said, "There isn't much financial incentive for private and voluntary hospitals [to admit AIDS patients]." Dr. Lansing had a strong opinion about the treatment and effect of AIDS upon health care:

"Every hospital will have to absorb AIDS patients. Each will have to share in the burden of cost. More and more AIDS patients will become indigent and I think we'll either see either a decline in insurance coverage for AIDS patients or we'll see specialty hospitals bidding for HMO, PPO or Medi-Cal contracts. If neither of those scenarios hold true, every public and private hospital could be faced with large, unreimbursed medical costs."  

Summary

California hospitals face a challenge, a challenge of staying in business. Medicare and Medi-Cal dollars are increasingly harder to acquire. Occupancy rates are among the lowest in the nation with the average hospital census
hovering at just above 50 percent. AIDS, or acquired immune deficiency syndrome, is slowly impacting hospitals. Many AIDS patients require long-term and very expensive care and hospitals may soon be forced to provide charity care. Non-reimbursed treatment for AIDS patients and non-reimbursed care for treatment of the indigent will force hospitals into a defensive stance against losing dollars. Patients not having the ability to pay face discrimination.

The focus on the two community hospitals in Riverside, reveals philosophical differences but no immunity from the national picture. Both are subject to federal regulations—peer review, certificate of need judgments, health maintenance contracting, out-patient competition—but both handle those situations differently.

Parkview and Community offer physician services, but the degrees of such services differ. Riverside Community appears to be more in touch with its medical staff than Parkview, yet both recognize the importance of each physician. Neither Parkview nor Community offer "guest" or "customer service" staff training. This neglect may be due to the lack of accepting the new business environment and the lack of accepting the changing health care industry and its environment. These changes and the responses of hospital's across the nation are outlined in the following chapter.
Chapter Three Introduction
Hospitals Change Attitudes While Fighting for Patients

Hospitals are asking the question, "Whatever happened to the 'good ol' days?" Those "good ol' days" of patients flocking to the hospital for every illness is past. Patients have become more aware of the costs as have insurance companies and the state and federal governments. That awareness is costing hospitals money. Some are paying a different cost--closure.

Closing is not entirely out of the question. Many hospitals have ceased operating (excuse the pun). Some hospitals are not accepting the change and are merely existing with lower censuses and fewer employees. Still others, unwilling to close or to just exist, have accepted the change and are prospering.

Hospitals are searching for patients, a definite departure from those "good ol' days." What form has that search taken? Advertising. Advertising goods and services. Unfortunately, hospital advertising lacks thought, lacks product differentiation, lacks a plan or a course of action or a call for a consumer response.

Health care is changing, but hospitals are not. Emphasis is still on "patients have to come to us," instead of "we should be going to the patients." Health care is still concerned with providing care, but because of an increase in consumerism, advances in technology, the rise in health maintenance organizations, and the spirit of entrepreneurship, hospitals must now become business oriented; service oriented. Empty beds and neighboring hospitals "stealing" patients are forcing hospitals to take a 180 degree turn in attitude.
Chapter Three
Hospitals Change Attitudes While Fighting for Patients

"Hospitals are suddenly fighting for patients..."^1 "Hospitals are stealing each others doctors, patients, market share."^2 In 1982, "the Supreme Court affirmed the [Federal Trade Commission's] antitrust case against the American Medical Association."^3 This federal "deregulation" led to the government's encouragement of "greater competition in the health sector."^4 That competition has led the health care industry toward "a business-like, market-driven... system."^5 Hospitals are now trying to discover a market. One simple definition of a hospital's market is the consumer.

Despite the fact "the [hospital] industry has always been very consumer-oriented... no one realized it until all the competition arose."^6 All that competition--out-patient services, contract bidding, etc.--has led to the selling of "new" medicine. There is always something new in medicine, but truly nothing (or at least little) is new about hospital care. It's hard to sell an old product, but hospitals are selling medicine, old medicine, by entering a new area--advertising. Unfortunately, "many hospitals begin advertising campaigns for the wrong reasons, such as in retaliation to a competitor's challenge."^7 (emphasis mine) Another reason hospitals are advertising is to avoid making difficult... decisions, i.e. how to change the established system.^8

Selling an Old Product

The difficulty in selling hospital care is partly based upon a marketing
concept—the product life cycle (PLC). The PLC reflects the "life" of a certain product be it Special K, hula-hoops or Edsels. According to PLC principles, a product can go through four cycles. The first is the product's initial inception or introduction into the market. If the product gains consumer acceptance, it then enters the growth cycle where sales increase. The third cycle is one of product maturation. This cycle is characterized by falling profits, consumer saturation, and slowed sales. Following maturation is product decline. "Business maturity arise[s] mostly from forces external . . . [including] market saturation, production overcapacity, displacement with new products, technical maturity, increasing consumer sophistication, changing fashions, and regulation."[^9]

A quick examination of the hospital industry reveals that business maturation (see graph below):

<table>
<thead>
<tr>
<th>External Force</th>
<th>Cause</th>
<th>Health Care Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market saturation</td>
<td>Decreased demand</td>
<td>Services leveling off</td>
</tr>
<tr>
<td>Production overcapacity</td>
<td>Too much competition</td>
<td>Excess providers</td>
</tr>
<tr>
<td>Displacement and technical maturity</td>
<td>New products replace old ones</td>
<td>New medical technologies provide out-patient health care delivery</td>
</tr>
<tr>
<td>Consumer sophistication</td>
<td>Education and options</td>
<td>Traditional health care obsolete; more consumer choices</td>
</tr>
<tr>
<td>Changing fashions</td>
<td>New styles, trends and attitudes</td>
<td>Less emphasis on hospital care; out-patient services are now the trend</td>
</tr>
<tr>
<td>Regulation</td>
<td>State and federal laws implemented to govern an industry</td>
<td>Certificate of Need; peer review; Tax Equity and Fiscal Responsibility; etc.</td>
</tr>
</tbody>
</table>

The demand for hospital services is leveling off as too many firms have

[^9]: [Citation]
entered the market, and new products are rapidly replacing old ones. New medical technologies are providing out-patient health care delivery, and patients are educating themselves to increase their health care options (HMOs, PPOs.) Out-patient services (FECs, free-standing surgery centers and specialty centers, i.e. birthing, dialysis, substance abuse, etc.) are utilized more frequently to save time and money. Plus, the health care industry is becoming more and more regulated.\textsuperscript{10}

The mature hospital business has a few options—adapt, exit or wait. Adapting may equate to hospitals starting an HMO or alternate care locations and public programs. Exiting may involve going out of business or specializing in certain areas of care—obstetrics, psychiatric, cardiovascular surgery, etc. Waiting involves timing, making the right decision at the right time, watching industry trends, and then deciding whether to adapt or exit.

\textbf{1,000 Hospitals to Close by 1990}

It is estimated (see page 83) that 1,000 hospitals will close in the next four years, making acceptance of the environment critical. "The most successful hospitals are asking the most basic . . . question of all--what do consumers want?"\textsuperscript{11} Consumers want quality health care at low prices,\textsuperscript{12} education,\textsuperscript{13} personal contact,\textsuperscript{14} hospitals to listen, and\textsuperscript{15} consumers want their doctors selecting the hospitals where they, the consumers, will receive care.\textsuperscript{16}

Adapting to the environment is tantamount to being consumer-oriented. Only when this orientation becomes the business of hospitals can a marketing direction be formulated. If hospitals continue taking the
approach that "we are better qualified to determine what is in the best interest of the public than the public itself,"\textsuperscript{17} the propensity toward failure, aka closure, is almost inevitable.

**Consumer Wants**

Knowing what consumers want and need will assist hospitals in making wiser choices in the business world. Hospitals, while a declining necessity, still hold a powerful position in the health care industry, however, because consumers have more health care choices, have more health care education and, ultimately, have more decision-making power. Hospitals need to be consumer-oriented.

Consumers want quality health care at a lower cost. They want education, personal contact, and someone to listen.

"Quality concerns moved to the forefront of today's health care issues... because of the fear that quality may be sacrificed by cost-containment efforts...."\textsuperscript{18} Under the prospective payment system (PPS), used for Medicare patients under DRG regulations, hospitals are encouraged to discharge patients sooner. As a result, the quality of care (and even the quantity of care) have been questioned. PPS officials are not sure, however, that enough data exists to render an opinion on lengths-of-stay and quality care: "Sufficient data do not now exist to determine the prevalences of these problems and whether [the problems] were caused by hospital responses to PPS. Access to and quality of care under the new payment system need further study and continuous monitoring."\textsuperscript{19} That monitoring, through the peer review organization, cited in a 1986 *Report to Congress*, stated, "[Mon-
itoring] has played only a limited role in quality assurance under PPS."\(^{20}\)
The report continued offering this possibility: "Earlier discharge under PPS could represent a decline in the provision of non-acute services to in-patients but not necessarily a reduction in quality."\(^{21}\) And yet in a congressional report this statement appeared: "At some level, further reductions in the lengths-of-stay will reduce quality, but that minimum level is not yet known."\(^{22}\) (emphasis mine) Declining lengths-of-stay will reduce quality, but the quantity is not known.

Because of PPS, Medicare beneficiaries are paying more dollars and are getting less care with possibly less quality. The Reagan administration wants less Medicare spending, while the elderly expect higher quality. At a 1984 Congressional hearing, Joseph Califano, former Secretary of Health, Education, and Welfare, said:

"As we strive for affordability . . . we cannot overlook the need to maintain quality. After all, if it is a relative of yours on the operating table, you want to know that the physicians and staff performing the surgery are well-trained and qualified to be doing the delicate job. That quality costs money. Someone has to pay for the training that went into educating doctors and nurses. Someone has to pay for the research that went into developing the drugs being administered. And someone has to pay for the high-tech equipment being used to diagnose and monitor the patient."\(^{23}\)

Since Lyndon Johnson that someone has been congress, but now, under Ronald Reagan, that someone no longer wants to pay or at least, not pay as much. The elderly are stuck between the proverbial "rock and a hard place," and are ultimately paying more for health care with less means to do so.
Along with quality at a reduced rate, the public wants to be made well or, better stated, kept well and thus alleviate the need for hospitalization and utilization of health care services. The public wants to be educated on how to stay well. "People expect hospitals to be the health care centers of the community." The public wants hospitals to educate and provide answers not just treatment. "Wellness programs" are now being promoted and sponsored by hospitals to keep the public well (and pacified). These programs come in various forms, from health fairs and free health screening programs to specialty programs, i.e. cardio-vascular fitness, CPR, diabetes tips, weight control methods and stop smoking clinics. The ultimate hope for hospitals in providing these programs is "brand name" recognition. If an individual (consumer) should become ill he or she would then select the hospital which cared enough and provided that community program.

High-touch

"The advent of automated tellers in banking gave rise to a countermand by many for access to a personal banker. The more we are faced with high-tech, the more we want high touch." A 1978 survey, cited in the book, The High Cost of Healing: Physicians and the Health Care System, concluded that physicians should be more concerned about personal relationships with patients than they are now. That survey found approximately 30 percent of patients believed they knew more about their own health than did their doctor; 48 percent believed they could get better medical attention; 40 percent believed family doctors were in very short supply. The quality of personal contact dictates the course of a patient's health care choices.
However, the most intriguing consumer need, contrary to the previous paragraph's claim, is that of having a personal physician select the location for health care. "A hospital's ability to attract, retain, and develop physician practices will perhaps become more of a discriminator of hospital performance than in the past [as] the physician will remain the principal gatekeeper in those markets where 'freedom of choice' insurance packages continue to be the dominant form of health insurance." In a survey conducted by Professional Research Consultants and Hospitals magazine, 36.9 percent of consumers surveyed in 1984 said they would leave hospital selection entirely up to their physician. That figure increased to 47.3 percent in 1985. The survey also detailed declines in individual or an individual's family selecting the hospital (1984, 42.2 percent; 1985, 39.5 percent). Declines also occurred in individual selection with physician help (1984, 20.9 percent; 1985, 13.1 percent).

It needs to be said that this survey differs from a 1984 survey published in The Journal of Health Politics, Policy and Law. That survey found consumers relying more on self or family to make the selection of a hospital (27 percent) and also relying more on self with physician help in selecting a health care provider (33 percent). Yet in both surveys, the physician has a large influence over hospital selection and hospitals are recognizing that fact. Typically, most physicians have admitting privileges at two hospitals. Thus, a patient can be admitted to either one. To attract patients then, a hospital must attract physicians and influence physician choices. This is being done in unusual ways. Hospitals are influencing physician selections by offering them access to lab services; continuing
medical education; patient record keeping; clerical, billing and insurance-
form processing services; nursing and office staff backup; office space;
scheduling and; a referral service.

These surveys on consumer choices indicate the three markets to be
pursued by hospitals--consumers, physicians, and health plans.

**Hospitals Hope Advertising Will Attract Patients**

If hospitals are a business, what product or products are offered?
Care? Nursing? Treatment? Hospitals are part of an industry "dedicated to
what's known as 'the most intimate of human services.'" Albrecht and Zemke, authors of *Service America: Doing Business in the New
Economy*, contend there is a shift away from products and toward ser­
vices. "Service ... makes a great deal of sense in virtually any industry
that deals in an intangible product or in an industry where products are
relatively indistinguishable from one another. Examples are airlines, banks .
.. hotels, restaurants ... theme parks, hospitals ..." (emphasis mine)

Hospitals need to learn how best to differentiate products (services)
from other hospitals and other competitors. Say Albrecht and Zemke:

"To survive and prosper in a service industry requires differen-
tiation. An effective service company must show evidence
that it really does have something special to offer ... especially
in industries where customers don't readily see important
differences in the choices of service offered them...."

Differentiating hospital services is much like "the hamburger industry
recognizing that customers must learn 'fried' is different from 'flame

46
Unfortunately, attempting to differentiate one hospital from another is similar to McDonald's comparing its McDLT to Wendy's Big Classic. Hospital advertising has focused on general products or services which all other hospitals have, and little thought is dedicated to specific goals or objectives for the ads. The results of such advertising has been consumer suspicion.

"Advertisers [are making] increasingly strident claims about pricing and service to attract consumers. But such claims could haunt advertisers in years to come, especially if [advertisers] compromise the consumer's perception of quality care." Quoted in Advertising Age, Dan Beckman, president of Health Marketing, said, "Some of the advertising is suspect. There's a lot of puffery, too much shouting of aspirations, 'we care the most'--and soft claims that aren't substantiated. You look at the ads and don't see a marketing plan." No plan, no goal, no direction, and "the distinction among major elements in the health care sector [becomes] blurred." "As consumer advertising for health care services continues to grow, another trend is clearly emerging--consumer confusion."

White Noise Advertising

Because many hospital administrators believe advertising is the cure for a slumping in-patient business, they continue to barrage the media. Arthur C. Sturm, Jr., president of Sturm Communications Group, calls this barrage "white noise advertising" and, he believes, the white noise will continue because of "health care's overriding lack of differentiation... [Health care advertising] all blends together to make one indistinguishable
sound. Sturm breaks the noise into styles or periods.

The first period health care advertising was "early clever," and as an example, he cited a display ad by a Catholic hospital for its maternity service. The ad showed a nun holding an infant with the tag line stating "Sister Mary So and So wants to have your baby." The "early clever avoids differentiation and . . . emerged [because] there simply wasn't a well-defined product."

Although most health care advertising is still in "early clever," many have entered the second style which Sturm classified as the neo-obtuse. This style promotes high-name recognition, but fails to differentiate the product and fails to persuade the consumer to an action. The "neo-obtuse" style requires large capital outlays and reaps little return. "After putting a lot of money into health care advertising, hospital administrators [are] demand[ing] to see results from . . . advertising dollars . . ." which is why advertising expenditures increased 25 percent in 1985 a significant drop over 1984. According to Steven Hillestad, vice president of marketing for Abbott-Northwestern Hospital, many hospitals are exercising caution and not wishing to spend advertising dollars until a "good product" is established. (Final 1986 health care advertising expenditures totalled $1.1-billion, an increase of 60 percent over 1985. Has a "good product" been found?) Frank Bradley of Stiles/Bradley, a Tennessee marketing consulting firm said in Hospitals, "[It is believed] "health care marketers are several hundred thousand dollars wiser." Apparently, that "good product" has been found. What that good product is, however, is not known as "hospitals have not seen expected shifts in admissions and market share." If that good product is
ever clearly established, health care advertising can then enter Sturm's final style period, "perfect clarity."

Perfect clarity can be classed as the differentiation of a product prompting an action from the consumer and increasing brand (hospital) awareness. But before all this display perfection is attained, a solid marketing program must be developed in order to establish a good product and what goals the hospital has established for that product. "Marketing [has become] the major buzzword in health care in the 1980s."52

"Hospitals ... have existed merely by sitting back and being available for those who are sick or injured."53 Generally, that is still the case, however the environment has changed significantly enough to alert hospitals "to wake up and smell the coffee."

Marketing professionals are now being sought to guide hospitals through the current crisis facing the health care industry. The more astute hospital administrators have recognized the need to formulate marketing strategies. Long-ranged goals, drafted in the 70s, were not insightful enough for the rapidly changing environment of the 80s. Unfortunately, few health care marketing professionals are available. Hospitals are hiring individuals with sales experience, thus confusing sales with marketing.54 The result has been the above noted advertising sales pitches and expenditures with short-sighted reasonings.

Selling medicine is less popular in the Pacific Coast region of the U.S. than in other regions. Twenty-nine percent of all hospitals in California, Washington, Oregon, Alaska, and Hawaii, did not advertise.55 The reason for this abstention is, as some claim, the patients pay for the ads.
"Hospitals across the country are embarked on high-priced advertising campaigns that you as patients will pay for," said Nathan L. Boring, director of planning at Wilkes-Barre General Hospital, in *U.S. News and World Report*. "The underlying message is that one particular facility is better than the one across town. Invariably, the hospital across town responds with a promotion campaign of its own. In the end--", Boring said, "if there is one--the community is no better served than before. But in the process, several hundred thousand dollars will have been added to the community's bills for health care." Yet despite dwindling revenues and efforts to cut costs, independent hospitals, sensing the need to be perceived as part of the community, are advertising to remind service areas "we've been here 1,000 years." These independent community hospitals are pushing *convenience* and a *personal* business nature. (emphasis mine)

**Advertising Expenditures Hurt Patient and Worker**

If it is true that community hospitals are pushing, if you will, personal (customer) *service*, why then are the front line employees being neglected? These front line people deliver the service to the customer, but "are the least important [people] in the organization draw[ing] the lowest pay, get[ting] the least training and development, hav[ing] the lowest potential for growth and advancement, and hav[ing] the most turnover," say Albrecht and Zemke. These are the individuals who are "the crucial point of contact. [This contact] presents the greatest opportunity for gain or loss. ..." The front line people in most hospitals are the admitting and business staffs; the emergency room personnel, the auxiliary (volunteers), the lab, x-
ray, inhalation and other support personnel, and the nurses. These are the people who are seen, touched, and talked to more by the customer (patient) than any administrator and represent the hospital better than pages of advertising. Yet these are the individuals with the lowest pay and motivation. Could that $1.1-billion be better spent on improved front line salaries and customer service education? The answer is yes.

A 1986 study done by SRI Gallup for Hospitals magazine found that a hospital receives the least amount of marketing support from supervisors, physicians, the hospital board, nurses, department heads, and support personnel. With marketing managers making hundred thousand dollar mistakes, and with no increase in hospital censuses, maybe major marketing efforts should take place in-house:

"The most effective marketing approach begins from the inside out, for only when marketing becomes everybody's business, can an institution foster the consumer awareness needed to develop focused and achievable objectives. Thus to be viable, all systems in the institution must understand and become sensitive to organizational marketing needs."  

Summary

If hospitals are facing closure, the adoption of a new attitude can only be a change for the better. This new attitude must reflect the new consumerism sweeping business--service. Hospital administrators have to start listening to consumer wants and have to begin an attempt at providing those wants. The health care industry is rapidly changing from the previous emphasis on in-patient services and is now focusing on out-patient services.
The market has shifted away from the hospitals and into easily accessible, convenient, and friendly clinics. Those hospitals failing to see this shift away from in-patient services have made mistakes—advertising mistakes—costing thousands of dollars. Those advertising dollars could have functioned much more efficiently in-house than in wasted advertising space.

Instead of believing sales and advertising are marketing, administrators would be better advised to hire true marketing people who know that an ad in the local paper is worthless unless research on a tangible product has first been done. Marketing professionals also know to neglect the hospital's staff training is among the top mistakes hospitals and businesses are making. A comprehensive educational program aimed at the support, front line people would better benefit the hospital than numerous column inches providing white nose and confusion.
Chapter Four Introduction
An Analysis of Hospital Advertising

Advertising is not marketing, but is one of the final stages of a long, carefully planned marketing strategy. The mistake most hospitals make today is confusing one for the other. Unfortunately, that mistake is costing hospitals, hospital staffs, and consumers a tidy sum of money.

This chapter looks at what marketing is and what hospital "marketing" directors should be doing with their time and their hospital's money; it defines advertising styles (beyond Sturm), and it analyzes the advertising of the two local hospitals used in this study—Parkview and Community. The criteria used for this analysis is contained within this chapter. The ads can be found in appendixes "B" and "C." Fortunately, both hospitals have progressed from Sturm's "early clever" stage, but much of the advertising remains "neo-obtuse." A quick review of Sturm's stages:

**Early Clever:** Cute, no product, no differentiation, no action.

**Neo-Obtuse:** High name recognition, an undifferentiated product, no action.

**Perfect Clarity:** A product differing from others, a call for an action, increased brand awareness.

The ads are grouped into other areas which *Hospitals* magazine established after surveying 200 hospitals nationwide:

- special service
- technology
- physician referral
- local appeal
- satellite
• cost to quality

The ads are also evaluated for content (copywriting), graphics (how the illustration helps/hinders the ad), gaze-motion (eye movement) and overall appeal (persuasiveness). This analysis will also attempt to discover whether marketing research was conducted, or if a marketing plan was first initiated prior to placing the ad. This will be difficult, but often ads themselves can reveal this by placement, number of runs, and content.
Chapter Four
An Analysis of Hospital Advertising

The recent trend in health care has been marketing, although the term to health care professionals has a myriad of meanings. In general, "marketing" for the health care professional means sales or advertising. Both sales and advertising are a part of marketing, but these two facets are end-stage results of an overall marketing plan. The diagram on page 57 details a typical marketing plan. A brief explanation will be provided here.

A marketing plan starts at the top with corporate management. Management assesses its corporate culture; its attitudes and history; its philosophy toward employees, and its products. This leads to a purpose of being or the corporate mission and objectives. A mission statement defines why the business exists. The marketing opportunity analysis explores the company's strengths and weaknesses. It also monitors and attempts to predict the environment looking for changes and possible effects those changes might have upon the company. Marketing research takes place to establish buyers behaviors, a target market and an analysis of that market. Strategies are then established on how best to reach the company's prime buyers and, during this process, the product is clearly established along with price, promotion ideas, and distribution practices. Marketing objectives or goals for the product are established, and communication of those objectives are clearly spelled out.

More and more marketing information is gathered to access the product's chances in the market. Then, the marketing mix places the product, the price, the promotion, and the place (distribution) into the market place. A quarterly analysis is done over the first year of mix and,
depending on the results, the product, price, promotion, place is evaluated for any changes. A feedback or response to the product is attained through continued research. Questions are asked: Is the product reaching its target market? Is the product responding to the needs of the buyers? Are sales as expected? Is the advertising channeled properly? Finally, evaluation and control of the product and corporation is done to evaluate corporate mission, the initial marketing analysis and the strategic marketing development. Controls are placed upon any area in the enterprise which might not be fulfilling the corporate mission and objectives. Plus, further analysis is done on the product's characteristics.

As briefly reviewed above, sales and advertising are several steps down a long line of research, monitoring, planning, and developing. Placing an ad in the newspaper or in another medium without going through the following steps is a waste of money.

In an attempt to establish criteria for advertising, the following items will be used to examine some of the ads Parkview and Community used during 1986. The outline on page 63 compares the number of column inches used by both Parkview and Community in Riverside's main daily newspaper.

**Categories for Hospital Advertising**

In a recent review of nearly 200 hospitals nationwide, Hospitals magazine found six main categories and one minor category in which to lump hospital advertising: special service, technology, physician referral, local appeal, satellite, and cost quality.¹
Marketing Management Decision Framework

Planning for and Acquiring Marketing Information

Analysis of Buyers Behavior

Corporate Philosophy

Corporate Mission and Objectives

Monitoring and Predicting Environmental Influences

Marketing Opportunity Analysis

Selection of Target Market

Market Segment Analysis

Marketing Strategy Development

Coordination with other Functional areas in the Enterprise

Marketing Objectives

Designing the Marketing Mix

Product, Price, Promotion, Place

Marketing Program

Response of Target Markets

Evaluation and Control
A cost to quality ad generates a sense of suspicion from most consumers. Something too good to be true usually is. "Appealing to consumers through price alone immediately calls the quality of services into question. Better ads make a logical case for economy of service—such as touting the low cost of ambulatory surgery—because that requires less hospitalization."^3

The local appeal ad category attempts to "build hometown trust and local pride,"^4 but the local appeal ads often reiterate services of, not just the hospital placing the ad, but of most hospitals in the area i.e., a 24-hour emergency department. To truly be appealing, the ad must emphasize a "preeminent service" i.e., a trauma center.^5

Related to the local appeal is the satellite category. This approach to advertising is "more active" by "exploiting the advantages" of geographic accessibility to the fullest by taking health care services out of the potentially intimidating hospital environment and putting these services into a more neutral territory. This involves putting extensions of hospital care i.e., urgent care, into a community area.

Physician referral ads tend to "confuse audiences"^6 as many believe it is the physicians who should call to take advantage of the service. Smart marketing research acquired prior to the launching of the referral service would benefit the ads. James H. Morris, senior account executive for the Kingswood Group, Inc., said in Hospitals, "Start with a name that prospective patients can identify with. [Instead of Physician's Referral Service, call it] CareNet."^7
Most weak ads come under the technology category. The temptation is "to put product shots of new multimillion-dollar scanners in the center of the ads." The better ads stress benefits—"reduced pain, faster cures or saved lives—in short, how new technology helps people." Most ads, 54 percent, were categorized into special service. This category is best used to emphasize marketing research—"reinforcing institutions' strengths coupled with knowledge of what sets . . . hospitals apart" (differentiation). These ads typically display drug and alcohol recovery, diabetes or other specialty services.

The seventh category catches hospital advertising aimed at making people "feel good" about the institution" or image advertising. According to Morris, "Image advertising is best left to those with pockets deep enough to sustain it." Image advertising is done mostly by "market leaders . . . to increase . . . their own largest share. . . ." If an ad does not fit into any one of these seven categories, for the purpose of this study, an eighth category will be added: Circular to reflect in which file the ad should be placed.

The Goal of Advertising

"The word advertising comes from the Latin ad vertere, meaning 'to turn the mind toward;'" a persuasive form of communication. To be persuasive, the ad should communicate and prompt its reader to an action. Advertising should have "two major threads: a marketing foundation and persuasive communication." To be truly effective advertising must complement marketing. The ad should reflect "marketing goals and
strategies, identification of prime prospects, product characteristics, and should have an adequate budget to insure proper communication.

"For advertising to be effective, a combination of at least some of the following conditions must be present:

1. It is of primary importance that the product be good and meet a perceived need.

2. Before considering advertising, a company must examine the potential for sales, revenues, and profits from its products.

3. Product timing . . . having the right appeal for the right product . . . with the product being . . . a lot better and a little different.

4. The product should have a unique, beneficial differentiation for the consumer.

5. The price must be right."  

These five points further emphasize why advertising is the end-stage result of a marketing plan. If the product being advertised has nothing special to offer, is not different or is overly priced, the success rate is greatly diminished if there is no planning or forethought.

A Look at Parkview's Advertising

With Parkview being the smaller of the two Riverside hospitals, one would, without doing any marketing research, look for Parkview to advertise what sets it apart from Community. This could be Parkview's ambulatory surgical center, its Curtis Cancer Center, its MRI scanner or its maternity services (Parkview started as a maternity-based hospital and added other services after expanding).
A look at its 1986 advertising shows where Parkview has been putting its advertising dollars. (See Parkview's ads on pages 106-114.) Parkview does not utilize radio or television but mainly newspaper and magazine. It did utilize a direct mailer titled "Health Scenes," but has ceased doing so in late 1986. A full-page ad (page 106) appears monthly (usually rotating with the hospital's physician referral service ad) in the Inland Empire Magazine. This ad is general in nature and can be classed as "image" as it does not outline a specific service but several specific services: emergency, the cancer center, physician referral, day surgery center, maternity, drug recovery, and home health care. The emergency department is mentioned twice. Arthur Sturm might call this a "noisy," neo-obtuse ad, as it does not truly differentiate any one service and asks for no action, but instead, promotes name recognition. The ad does remind the hospital's service area, "we've been here 1,000 years" with the tag-line "serving Riverside and its surrounding communities for over a quarter of a century." The ad is balanced (the left equalling the right) but the ad does not pull the eye through it. The bullets which offset each service works as optical stepping stones (gaze motion, the eyes "stepping" through an ad). File this ad under image.

Parkview, under the auspices of Arlington Health Services, advertised its new occupational medicine center (pages 107 and 108). The ads say the same thing with one having a display picture. Both have maps and both stress "seven days a week--24 hours a day." A closer look at the first ad (item two) reveals that the center is "a service of Parkview Community Hospital" and has "no wait--walk-in service." The second ad does not say anything about affiliation and, although it says "no wait--walk-in service,"
the listing above the telephone number says, "appointments." That may be confusing to a consumer. The ad is balanced with the same bullet-effect as seen in the previous ad. These two ads could be filed in specialty service and, a remote possibility, satellite as the facility is located away from the hospital, albeit across the street. This ad is neo-obtuse.

The ad for Arlington Radiology Medical Group (page 109) shows the same picture as in one of the occupational ads. It states the facility has "state of the art" equipment, is "convenient" (although 8-5 Monday through Friday is not considered convenient by most consumers) and has "reasonable rates." The ad is balanced but the eye is not pulled through the ad. Ads are generally "S" shaped or "C" or reversed "C" in layout. These methods "pull" the eye through an ad. This ad, not unlike the other three, is laid out in an "I" shape--straight. This is a service-type ad but falls into the technology and cost-quality categories as well. Again, no action is asked for, nor is there any real differentiation--neo-obtuse.

"Parkview Community Hospital announces the opening of the Riverside Regional Cancer Center--The first 24 hour, 7 day a week out-patient cancer center." One's first thought about this ad (page 110) is so-what? No other information is there. What is an out-patient cancer center? This is a poor ad asking nothing of the reader and telling the reader nothing--neo-obtuse. The ad's intent was to communicate a new service but fails to do so. The date of the opening is buried beneath a small-type phone number. There is balance but the eye focuses immediately on the word "cancer." File this ad under circular. It is interesting to note that no other ads followed this one. What was the plan?
Advertising Comparisons—Community and Parkview

June 1986.
The next ad uses a provocative headline to grab attention: "The first symptom in 40% of all heart attacks is SUDDEN DEATH" (page 111). The problem with "shock" headlines is the reader will often believe he or she has been manipulated into reading the ad. This headline backfires by immediately associating Parkview with something negative—sudden death. The eye is pulled through with a "C" motion, but after "sudden death" the eye does not sweep through the copy, but instead goes to a graphic of a man clutching his chest. An important bit of information is buried: "This program is limited...." A better headline could have suggested preserving life instead of emphasizing death i.e., "One hour and $98 could save your life;" or "Improve on life's chances." This is a community service, as the copy states, but misses serving the public. Instead, the ad scares a reader away and possibly away from the hospital. File this under circular.

The history behind the next ad (page 112) may explain the ad better than the ad explains itself. Parkview has been a Champus (military insurance) carrier for many years. Because officials at a local air force base (March AFB) came to the hospital asking that Parkview "market" champus maternity services (March's tiny hospital has no maternity services), a series of five, full-page ads appeared in the local press. Because this ad mentions cost, file the ad under cost-quality. The ad is noisy. There is too much information to read and, assuming Riverside consumers are no different from the rest of the nation, few ads get more than a split-second look. The gaze motion on this ad is a "CI." The eye starts with the graphic of mother and child and the "$25 tag," but then all is lost. The ad is clumsy and unbalanced. There is no unity; nothing ties the ad together. The selective
headline, "Attention: dependents of active duty military personnel," targets an audience. The hospital did receive numerous calls from Champus beneficiaries asking questions unrelated to maternity i.e., "Can I have my gallbladder removed for $25?" Sturm would call this ad (then, again, maybe he wouldn't call it an "ad") neo-obtuse.

An obvious physician referral ad (page 113) is truly noisy. One of the most important items in an ad for a referral service is the phone number. The phone number appears three times, in bold but small print. The major draw in this ad is the arrows pointing to various places on a form thus acting as optical stepping stones. The arrows, however, tend to create an even busier ad. The ad lacks unity. A more simplistic design may have been a better attention getter than this full-page, noisy ad. This is a mix between early clever and neo-obtuse.

The last Parkview ad to be analyzed (page 114) is one for its maternity services. "New lives begin at Parkview . . ." is the headline with a very attractive graphic, however the ad is too compacted with information. There are three different phone numbers contained in the ad: one, to make reservations for a "maternity tea," one for the hospital, and one for emergency services. This is a specialty service ad, but with too little stress on the desired action. The maternity tea could have been the prompt for an action and should have been more accessible in the ad. The ad is balanced, but has no true draw through the ad; no shape. The ad lacks unity. It is an early clever ad demonstrating no specific product and asking the consumer for no specific action. After the graphic, forget it. The "tea" invitation is at the bottom of the copy, but should have been just under the headline: "New
Lives Begin at Parkview Community Hospital. Join us for tea and find out why." This would help in providing a specific action for the reader to follow. Next, provide a brief explanation and make sure the number for reservations is seen soon after. Period. No clutter.

**Summary and Recommendations for Parkview**

In a November, 1986 interview, Dr. J. Dee Lansing, then president of Arlington Health Services (Parkview's parent company), said Parkview's advertising plan was to show how Parkview differed from other hospitals, how Parkview was better and, because it was a small hospital, how it could provide better care. Nowhere in these nine ads or in any other Parkview ads is the notion of "smallness provides better care." Quite the contrary. The ads reflect upon Parkview's smallness as a liability: "A full service hospital and medical center meeting your complete health care needs."

A review of a number of ads placed in 1986 demonstrates a randomness of product attention. No one service is advertised over a period of time thus demonstrating a lack of a comprehensive marketing plan. Very little differentiation, if any, can be seen. Parkview's administrators believe that marketing is advertising. That statement is best proved by the five consecutive full-page ads for Champus babies. According to Parkview's admitting manager, no increase in champus maternity admissions was realized after the ads ran.

Parkview's administration is stuck on the idea that advertising is marketing, or that selling is marketing. (Parkview's current marketing director has a sales background.) Recommendations for Parkview:
1. Formulate a comprehensive marketing plan that would include finding a target market; differentiating products; performing some basic market research to establish product need and consumer want; basing future advertising on specific service products and; looking for results from the advertising dollar spent.

2. Use less display space and less clutter in the ads remembering the limited amount of time the average reader sees an ad. Limit the amount of copy thus eliminating the need for so much ad space. Simplify the copy.

3. Evaluate the corporation's philosophy and objectives. Clear up any confusion over whether smallness is a strength or a weakness. If, after a determination has been made, emphasize the strength; minimize or change any conceptual weaknesses.

4. Better copy writing would help reduce some of the clutter and would make more sense. Examples of poor writing: "Which is a lot more information than any other referral service supplies." That stands as a complete sentence. Likewise, "So you can get the answers you need."

A Look at Community's Advertising

According to Community's vice president of marketing, Phil Dalton, health care professionals are starting to talk like product managers:

"There are some traditional products . . . available in health care like durable medical equipment or pharmaceuticals--something tangible--but when you start talking 'what is the distinction,' the language is becoming blurred. The product is, in one sense, a service. I . . . have to say . . . using the word 'product' not only applies to services, but it applies to a mechanism of organization. People are buying health care services as a total package and that becomes the product. It's really hard . . . to come out with some clarity in terms of product vs. service. When you get down into defining what your different services
are, they're either the product itself or they're part of a larger product."23

Community advertises more than Parkview. Community has utilized radio, billboards, direct mail, and print media. Approximately four percent of Community's total operating budget is for marketing.24 Hospital marketing budgets can be from "one to ten percent. The more intense the competition, the greater the marketing budget."25 According to Norman McMillan, author of Marketing Your Hospital: A Strategy for Survival, "A 'mature' marketing budget [should] make up 1.5 percent of a hospital's total annual operating budget."26

Dalton said about advertising: "It's the end point of a marketing strategy. It culminates a whole series of steps that would comprise marketing"--market research (including consumer, patient, and medical staff interviews); environmental assessment; competitor profiles; internal assessment; feasibility studies and; the development of a marketing strategy.27

**Very Little Image Advertising**

After conducting extensive marketing research, Community discovered it had no image problem. It found that it competed with Parkview for maternity patients specifically, and with Loma Linda University Medical Center generally. "Having an image is declining in importance because of how people are basically gaining entry into the health system," Dalton said. "They're not necessarily picking a hospital, they're picking a health plan.... Some people pick a hospital by how tall it is."
"If you have a good image [why] spend a lot of money on image advertising [when] it's not affecting people's decisions? There's no definitive development." 28

Community has recently developed many "product lines," advertising each (see pages 115-123), and recently opened a CareUnit, an alcohol and drug dependency treatment program. 29 One product line Community has been advertising with regularity is its Maternity Care Associates of Riverside, a maternity service located away from the main hospital. The ad (page 115) directs the eye from the very large photo of mother and child to a teddy bear sitting in a safety car seat and the word "free." This is a specialty service ad and confirms one of Community's ad philosophies -- establish a physician base. The ad has a "C" shape going from photo to "bear." The ad is balanced and has unity. The reader, once attracted to the specialty headline, is rewarded with the thought, "I've read the ad and I can get something free." Although indirect, the ad prompts an action. Differentiation, action, and specific product -- Sturm would classify this as perfect clarity.

"Cataracts deprive you of life's little treasures." This ad (page 116) is specialty service and is simple enough to get one to read it. The specialty headline is the first draw followed by the picture of grandmother and grandchild. The phone number is positioned right by the graphic. The ad is informally balanced. The "weight" of the ad is in the lower half, below the optical center (which is located about 3/8 of the way down the page). The copy is simple, complete with a few incomplete sentences. This full-page ad has also been reduced to a quarter-page ad and is just as effective although the copy
could be a little larger. If someone does have a cataract, reading that small print may be difficult. Product and action with differentiation makes this a perfect clarity ad.

The physician referral ad (page 117) demonstrates simplicity and, judging by the facial expression presented in the photo, a reassurance that calling 788-FIND will provide one with a good physician. Unfortunately, Community couldn't find a better name for the service. The ad is in an "S" shape, is informally balanced but has unity. The phone number is prominent and appears in two places--in big type and in small type. This ad refers to an action, but doesn't differentiate Community's referral service from Parkview's. (Parkview's ads attempt too much differentiation, but fail because the ads are too noisy.) This ad is neo-obtuse.

The ad for the "culinary hearts kitchen course" (page 118) is another specialty service ad and is an ad for a "wellness" program, part of Community's "HeartCare Program." The ad is informally balanced and follows a "C" pattern of lay out. Although in bold, the "enrollment is limited" and the phone number should have been more prominent. The interesting part of this ad is one of marketing nutritional services. An article in the February 1986 edition of Hospital Material Management Quarterly, titled "Use of nutritional support systems to meet hospital marketing needs," encourages hospitals to use nutritional services as a public draw. Hospitals are supposed to know all about health and health preservation and what better way to show that knowledge then by teaching the public how to cook and what to eat?
"The Family BIRTHplace" (pages 119-121) is a result of consumer research and patient interviews. The maternity services at Community underwent numerous changes in order to attract consumers. The ads are the end result of planning a marketing strategy. (Community once lagged behind Parkview in the number of maternity admissions, discharges, and births, but has now surpassed Parkview and other area hospitals.) These ads—communicating childbirth classes; changes in the maternity wing, its policies and practices and; inviting expectant mothers to visit the BIRTHplace—are simple, attractive, and present a theme throughout: Riverside Community Hospital is the family birthplace or, as the ads state, "Starting family life together." The ads are an excellent display. Put all in the specialty service category. There is differentiation, a specific product, and a call for an action making this ad one of perfect clarity.

A switch (page 122) in advertising practices came in December. An image ad. "Wishing you holiday health and happiness, Riverside Community Hospital." The ad appeared a few times during the month of December. It is simple with no other copy save an address and phone number. The hospital's name, address, etc. is small compared to the message. Did Community feel its image had slipped? The ad draws the eye in a "C" motion, is informally balanced and has no real unity, but with the simplicity of the ad, its lack of unity does not hurt the message. The ad is neo-obtuse.

Finally, an ad for the hospital's HeartCare program (page 123). Although this ad started appearing in 1987, the build-up for this promotion started in 1986. The ad asks for a response: Call 68-HEART and has a clip-and-send coupon entitling the sender to receive free information. According
to Dalton, these ads are the first Community had placed a clipping in. "We've had a good response; more from the mail-in [than] that from direct phone calls." The ad uses color, red for the heart, and has placed a heart above the heads of the three individuals. The tag line "think for your heart" thus works well.

**Summary and Recommendations for Community**

What a difference planning makes. Marketing is not advertising and advertising does not constitute marketing. As stated earlier in this study, advertising is an attempt to combat a competitor's ads or it's often a way of avoiding decisions about programs and products. The majority of Community's ad show planning, thought, design, and the results of marketing research which is done both in-house and with the help of outside firms.

Community has committed resources toward its organized and timely marketing efforts. A commitment to the consumer's wants and needs is reflected in Community's advertising. Recommendations are

1. Some of the copy could be better written. Avoiding incomplete sentences would reduce the amount of choppy reading.

2. Continue the use of graphics and photos. Continue placing important information i.e., phone numbers, as near to the graphic as possible.

3. If more advertising on the Bye Center is planned, make sure the individual with cataracts can read the copy. The reduced full-page ads to a quarter-page severely crippled the message. The selective headline targets cataract sufferers who should be able to read what the advertiser believes is important.
Local Conclusions

The conclusion/summary of chapter 4 might best be reflected in a statement made by Dalton regarding Parkview's advertising:

"A lot of the stuff [Parkview's] done has been tacky. I wouldn't say they're doing marketing strategy, but they're just strictly advertising."^^

Doing "just strictly advertising" is not enough in a very competitive and unsure industry. Community recently changed administrators because previous management was "stuck in the mud" having old ideas about doing business. The change has produced good results.

Parkview has had three administrators from the period of June '86 to July '87. The current administrator has a nursing background. Do not expect changes from this community hospital in the way it does business. There is still hope, however, for Parkview. The retirement of Arlington Health Services president and founder of Parkview Dr. J. Dee Lansing (an OB-GYN physician), may help the facility. His replacement has a business background.

Cause to Effect

This study has looked at California’s health care environment and specifically examined the City of Riverside’s two community hospitals. In chapter three, the challenges and problems of the health care industry were detailed along with the general advertising principles some hospitals use. Chapter four took a brief overview of hospital advertising and then applied specific principles toward the ads placed by the two Riverside hospitals.
Chapter four also summarized marketing principles as applied toward the end-stage of advertising.

Chapter five provides the cause and effect of why hospitals are advertising. The historical data supplements the first four chapters and provides more detail to how the federal government got involved and what happened to the health care industry after specific pieces of legislation were passed by various congresses.

It has been said, "To explore the past is to study the future." Chapter five is the past and chapter six is the future of the health care industry.
Chapter Five Introduction
The Federal Government and Health Care

The U.S. government has had the knack of sticking its legislation into a good cause and somehow lessening the original good intent. In 1935, the federal government dipped its hand into health care for the first time, and in the 52 years that have ensued, bill upon bill has been added many of those bills passed to lessen government's health care burden. Costs have been more than anticipated.

This chapter outlines the good causes, the original intents, and the results of trying to make a good thing, health care, better. Unfortunately, trying has made a good thing go from good to bad. Each new Congress hopes its bill is better than previous bills. History, however is against that hope.

This chapter is about history, the history of health care as influenced by presidents and congressmen. Fifty-two years is a long-time, but many of those alive then are alive today and they remember the rhetoric of lawmakers expounding on a better beginning for those citizens in need of health care.
Chapter Five
The Federal Government and Health Care

During John F. Kennedy's tenure as president, he asked his Congress to study the special health problems of the nation's elderly. The Committee on Aging found "one fourth of the nation's elderly had incomes placing them at or below the established poverty line," many merely surviving on social security checks.\(^1\) Despite low-incomes, seniors were spending 30 percent of their incomes on health care, or three times that of younger Americans. Health care services were utilized more often and recovery periods were generally longer. Thirty percent of the elderly were dwelling in substandard housing without adequate heating, plumbing or electricity, and their access to social services was limited.\(^2\)

The panel thus concluded: "Older Americans were not being provided with the health care they needed ... [and] faced ... [the choice of] spending their limited incomes on food or health care."\(^3\) Furthermore, "it was clear to Congress that the 'welfare medicine' offered to the aged, poor, and needy by the states or municipalities was uneven in quality and generally far short of what was necessary."\(^4\)

Title 18--Medicare/Medicaid

As a result of the Committee on Aging's findings, in 1965 Congress passed Title 18 of the Social Security Act--Health Insurance for the Aged and Disabled (Medicare and Medicaid. Medicaid was the major obstacle to the passage of Title 18, however Medicaid remains today despite its continued unpopularity with state and federal agencies.) Title 18 made "the federal
government . . . a major purchaser of medical care—indeed the single largest purchaser—and did so on behalf of the elderly and the poor. 5 What Title 18 also did was contribute to a steady rise in health care costs.

Health services usage rose as did prices and state and federal expenditures. In an attempt to stem those increases, Congress passed the Professional Standards Review Organization (PSRO) program in 1972. PSRO was to determine if the services provided were both necessary and up to standard. 6 This determination would include a review of services, hospital admissions, and lengths-of-stay. 7 PSRO was charged with the responsibility of determining whether care and services were appropriate.

Still another attempt at controlling costs passed in 1973. The Health Maintenance Act was initiated to provide federal funding for the establishment of health maintenance organizations or HMOs. An HMO "accepts contractual responsibility for making available and providing to all enrollees a specified range of medical care . . . in return for . . . prepaid . . . services." 8 HMOs make money by keeping patients well as, the more services utilized, the less the HMO profits. If patient visits and services are at a minimum, profits are at a maximum.

**Government Attempts to Slow Health Care Spending**

New legislation was in place and some of it started to work—PSRO began to "reduce the number of 'social' admissions and reduce the lengths-of-stay of 'non-acutely ill' patients" 10 and, employers began utilizing HMOs "instead of other physicians and hospitals [and were saving] about 10 per-
cent or more on the ... cost of health care." Yet, health care costs continued to rise.

On Medicare's fifteenth anniversary, 1980, the Select Committee on Aging opened hearings to examine and to decide whether Medicare had effectively helped the aged and whether the government could continue to provide financial assistance to the program. The committee found "there were five working Americans for every one ... retired. By the year 2020 that ratio would decline to two-and-a-half to one. This change would place a severe strain on [those] who will be contributing taxes to pay for ... Medicare.

"Older patients consume a proportionately larger percentage of the health care dollar." 13

In addition to a swelling of Medicare beneficiaries, the committee also faced health care increasing "three times as fast as the cost of living," doctors not accepting Medicare patients or not accepting Medicare as full payment, and an increase in Medicare regulations had "shortened Medicare's range of coverage." The committee debated utilizing HMOs for Medicare patients in hopes of reducing the estimated 20 percent growth in Medicare expenditures projected over the next 15 years. 16 This exploration "underscore[d] the willingness of the government to alter traditional relationships between doctor and patient in order to achieve policy goals and, in the process, ignore the original promise, written in law, not to influence ... fee-for-service medical care." 17 The committee also desired to make health care affordable for the elderly. (This same committee, four years later, admitted, "The elderly now spend ... as large a share of their incomes for health care as they did before the enactment of Medicare.")"
TEFRA and DRGs

The net result of the committee's hearings was the Tax Equity and Fiscal Responsibility Act (TEFRA) enacted in 1982, some 11 years after the Nixon administration first initiated the legislation. TEFRA assisted in the establishment of the 1983 diagnosis related group system for reimbursement of hospital costs accrued by Medicare recipients. This legislation "left behind ... a cost reimbursement system that ... had produced unacceptable hospital cost inflation." A diagnosis related group or groups (DRGs) placed "limits ... on the amount Medicare would pay a hospital" for diagnoses which have been classified and correlated with an appropriate dollar amount. (See sample DRG work sheet page 105.) DRGs are based upon a prospective pricing system in an effort to control costs.

Cost containment was the main thrust behind the TEFRA legislation but TEFRA was also to "encourage ... hospitals to lower ... expenses for in-patient stays." In 1982, Congress saw Medicare expenses reach $322-billion or 10.2 percent of the Gross National Product (GNP) and, in 1985, expenditures were between $25 and $425-billion, or 10.7 percent of the GNP. The initial impact of TEFRA and its DRGs was not immediately felt. However, the figure(s) for 1985 represent an 8.9 percent increase in health care expenditures, the lowest rate of increase in two decades. Health care costs occupied 10.6 percent of the GNP during the first quarter of 1986, a slight decrease from December of 1985. The governing board for the federal fund which pays Medicare attributed that decrease to the DRG system.
If declines continue, some politicians will feel less pressure, pressure Senator Durenberger felt in October, 1984. He said during a Senate meeting, "We are not at the stage yet [where] we [the government] will decide who lives and who dies." 30

Another attempt at reform, the Peer Review Organization (a renamed version of the Professional Standards Review Organization [PSRO]), has had little or no direct effect on lowering the cost of health care. It, instead, was to monitor the quality of care a patient received while hospitalized. According to a February 1986 Congressional study, "PRO... has played only a limited role in quality assurance... [and] does not monitor outcome..." 31 Peer review has not proven effective in reducing costs but, instead, has reduced some unnecessary hospital admissions.

U.S. lawmakers, by amending Title 18, have decreased health care expenditures. The last quarter of 1985 indicated a gentle slowing and 1986 is looked upon as the year for a major slow down. Yet, with every attempt at control, the government has inadvertently changed the delivery of health care. Two reasons can be given for that change: the Tax Equity and Fiscal Responsibility Act (TEFRA) and its subsequent DRG system of reimbursement, and the government's encouragement of competition among health care providers.

Congress developed the prospective payment system (PPS) to coincide with diagnosis related groups. Along with those two items came the ProPAC or Prospective Payment Assessment Commission to monitor the payment system. PPS, DRGs, and ProPAC have contributed to tighter purse strings on the government's pocketbook.
"On the basis of principal diagnosis and certain other factors [age, sex, secondary diagnosis, complications, surgical or non-surgical admission], each discharge is assigned to one of 468 ... DRGs for payment. The new payment system encourages hospitals to lower expenses for in-patient stays.\(^\text{33}\) (emphasis mine)

Along with principal diagnosis, the length-of-stay per patient admission is also a DRG concern. DRGs only affect Medicare patients but "25 percent of total hospital admissions" and "40 percent of total hospital days are by older patients."\(^\text{34}\) Lengths-of-stay for Medicare patients dropped 7.6 percent in 1984 and, in the same year, Medicare admissions dropped almost five percent. Hospitals appear to be responding to the incentives of per-discharge payment. \ldots\)^\text{35}

Unfortunately, DRGs and current Medicare policies are hurting Medicare patients. Medicare deductibles have risen over 1200 percent since the advent of Title 18. In 1965, Medicare beneficiaries paid the first $40 of their hospital bills. In 1980, that amount increased to $180.\(^\text{36}\) The deductible increased from $492 to $572 as of January 1, 1987.\(^\text{37}\)

Another Medicare policy that financially cripples the elderly is nursing home care payments. "Currently, the elderly must finance their own nursing home care until they reach the poverty level, [then] the ... program takes over."\(^\text{38}\) If there is a surviving spouse, he or she is totally impoverished with medical bills. Post-hospital care benefits are also being denied at a greater rate thus increasing out-of-pocket expenditures for Medicare beneficiaries.\(^\text{39}\)
DRGs give financial "incentives" to hospitals to discharge patients sooner. "The government has figured average cost for ... diagnosis related groups and will pay the hospital that amount per stay. If a patient is discharged early, the hospital pockets the difference. If a patient stays longer than the average, the hospital loses money." Syndicated columnist Harry Rosenthal said, "It doesn't take a genius to figure that hospitals want to be rid of you as soon as possible." "Older hospital patients are being released 'sicker and quicker' because of government ... medical cost-containment measures ..." a recent University of California, San Francisco study revealed. "Cost containment pressures ... encourage [an] early hospital discharge of elderly patients ... at times when they still need care." (emphasis mine)

Hospital's Medicare profits were in the 12 percent range in 1983. In 1985, profits were at least 17.6 percent but declined slightly in 1986 to 15.7 percent. One of the reasons for the overall profit increase is, according to health economists, "... a dramatic reduction in the lengths-of-stay, reflecting perhaps the premature discharge of some patients." The government calls this, the reduction in lengths-of-stay, efficiency, but Andrew Webber, president of the American Medical Peer Review Association, wonders, as reported in Hospitals, "When does too much efficiency move into underservice or undertreatment?" Other reasons for rising Medicare profits include "the success of hospitals in controlling costs and errors in the data and projections used to set Medicare payment scales."

There are more problems with DRGs. Because the government is insistent on saving Medicare dollars, projected up to $4.7-billion in 1987, a
five-year freeze is expected on DRG reimbursement rates. "Freezes [will] put ... hospitals (with large Medicare populations) up against the wall," said Edmund B. Rice, vice president and director of federal relations for the American Hospital Association. William B. Cox explains, in a Modern Health Care article, what being "up against the wall" means: A freeze would "force mergers or force some hospitals ... out of business." Cox, vice president of the Catholic Health Association added, "or sell out." Selling out equates to 55 to 60 percent of the nation's hospitals belonging to multi-hospital, for-profit, systems. It is believed, by 1990, "just 10 to 20 corporations--so-called SuperMeds--will provide the bulk of the nation's health care." A study, soon to be released by the Harvard School of Business, reportedly claims for-profit hospitals function more efficiently than do non-profit hospitals and it is for that reason, many non-profit hospitals are losing dollars and closing shop. Predictions have it that by 1990, 1,000 hospitals will close as a result of federal cost shifts (DRGs).

Despite the problems with DRGs, this system is here to stay. The system is saving Medicare dollars by decreasing lengths-of-stay for hospitalized Medicare patients. This decrease causes declines in hospital censuses and spells yet more problems for hospitals. Occupancy rates are now the lowest in two decades, averaging 66 percent. Decreased occupancy equates to decreased revenues. Figures for 1986 show one million fewer Medicare patients admitted to hospitals compared to 1983. DRGs are the main reason for declining occupancy rates, but, so too, is the changing environment and marketplace competition.
Changes in the Health Care Environment
Spell Dwindling Occupancy Rates

"Today’s health care consumer is much more interested in nutrition, health issues, and in preventive medicine." The health and fitness emphasis has taken a firm hold and has led to consumer awareness and to a self-responsibility toward personal health. "Patients are becoming more and more interested in being educated about the nature of their diseases, treatments, and the efforts necessary for disease prevention." "Seemingly healthy people are modifying unhealthy habits by signing up for programs to stop smoking, control weight, learn about cardiac care, and alter chemical dependency." A healthier America means less utilization of acute health care services.

"Today’s consumer is more educated about choices in the health care field . . . and they’re saying, 'I want this, I want a second opinion,' and they’re starting to get it." Health care has become a consumer’s market. They want the best deal and the best quality for their health care dollar. "There is a dollar mentality in health care today." "More and more consumers are shopping around for doctors as well as [for] hospital services." "Patients . . . now find more delivery vehicles and health benefits contracts from which to choose." Consumerism has led to the "come and go" forms of health care--Urgent Care Centers ("Doc-in-the-box" or "7-11 medicine") and Surgicenters ("M*A*S*H meets McDonald’s"). This consumerism has spread to big business, too, and more and more businesses are turning toward Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). "Through PPOs, firms and business coalitions have negotiated discounts for health care" from "groups of doctors and hospitals
These alternative forms of health care are removing in-patients from hospitals.

**Technology**

"Each day's news gives some account of innovative methods of prevention or cure." As technology heightens, hospital's in-patient services decline. Reason: "Many diagnostic tests and therapeutic regimens [can be] safely conducted in an out-patient setting which once required from 2-7 days of hospitalization to perform." (emphasis mine) Hospitals are purchasing high-tech medical equipment in an attempt to capture some of that out-patient business. However, purchases of state-of-the-art equipment increases the cost of health care for in-patients, even though out-patient costs would decline.

Finally, the overall economic situation has aided in decreasing hospital admissions. "Patients are less apt to come to the hospital for elective procedures or less severe illnesses."

**The Physician Glut, "7-11 Medicine," and Consumerism**

Health care consumers have more choices today than ever before, especially with their choice of physicians. The government's influence on the "physician glut" can be traced to the Health Manpower Act passed by Congress in 1971. Under this provision, grants and federal assistances were provided "to expand the scope of medical schools and increase the number of health professional students." The government also relaxed immigration
laws allowing and encouraging foreign medical school graduates into the U.S. The result of these two provisions—a glut of doctors especially in urban areas. In 1965, "there were 7,400 medical school graduates. In 1983... there were 15,700." Even with population growth, the number of physicians per capita continues to grow. "In 1960 there were 148 MDs/100,000 population. In 1978...171/100,000. In 1990, there will be 245 MDs/100,000 people or 70,000 surplus physicians." The abundance of doctors intensifies competition among the basic providers of health care and allows the consumer a wider range of choices. The physician glut also leads "directly to increased fees for specialty services, higher physician costs per capita, increased bed demand [(and increased hospital spending and expansion)], increased patient stays, and increased daily costs of hospitals." (An increase in patient stays or days, may result in further loss of income for hospitals as DRGs will not pay for longer stays.)

In Vital Speeches of the Day, Wes Poriotis, president of Wesley-Brown Enterprises, Ltd., a PR firm, tells about a call he got a call from his broker. The broker was attempting to get Poriotis to invest in a surgery center. "[Surgery centers] do ear, eye, nose, throat, endoscopy, gynecological, and general operations...more than 300 different types of surgical procedures. Consider the market," the broker continued, "twenty-five to forty percent of all surgeries could be done without overnight hospitalization. This country has more than 200 million people. The surgery rate is 70/1,000. If 40 percent of those could be done without staying overnight, that's a potential market better than five million cases a year." Poriotis was a bit skeptical, however others are not.
The first free-standing surgery center was established in 1970. Five years later, only five surgery centers existed in the U.S. In 1980, however 100 units were in operation seeing 200,000 patients a year. For 1986, the number of centers would nearly triple over 1980 with patient counts escalating to 900,000. These centers, fondly referred to as "M*A*S*H Meets McDonald’s," are price conscious, with costs 15-75 percent less than hospital costs;7 convenient, with registration and scheduling often done around the patient's schedule; pleasant; accessible and; taking in-patients away from hospitals.

"Doc-in-the-box" or "7-11 medicine" are the names attached to free-standing emergency centers or FECs. The first FEC was established in 1975. Over 600 were operational in 1982 with predictions of 4,500 in 1990. That number may be too low as more than 2,500 FECs were in existence in 1984. FECs steal the "cream" away from hospital emergency rooms (ERs). The reason--an average ER visit runs $115; an average FEC visit, $42. FECs are often more accessible, courteous, and involve less paper work. Hospital ER visits were down 1.6 percent in 1981. FECs grossed $838-million in 1984.

If you add the number of patients receiving services outside the hospital setting in FECs, surgical, diagnostic, birthing, women's, sleep disorders, diabetes, dialysis, eating disorders, and substance abuse centers, one could reason from cause to effect why hospitals are losing patients. And dollars. Insurance companies and the government are encouraging use of these centers as appropriate low-cost alternatives to hospital care.

87
HMOs

Prior to the HMO Act, passed in 1973, there were 26 HMOs in the U.S. with 2.9 million subscribers.\textsuperscript{84} The first HMO was organized by industrialist Henry J. Kaiser in 1943.\textsuperscript{85} The impact of Kaiser in and on California is stunning. Over 25 percent of California's population is enrolled in an HMO with 75 percent of those belonging to the Kaiser system.\textsuperscript{86} HMOs now total over 450 with 21 million subscribers.\textsuperscript{87}

Do HMOs reduce hospital occupancy rates? Indirectly so. "HMO's savings come primarily from keeping people out of hospitals."\textsuperscript{88}

Health maintenance organizations are believed "to encourage preventive services and early detection of illness ... and physicians ... act to avert later and far more costly hospitalizations."\textsuperscript{89} HMOs act on the principle of early detection, preventive medicine and less usage of services; the less use, the more profit. "The physician, ... compensated by a payment fixed in advance ... has ... incentive ... to encourage preventive medicine to avoid undue expenses."\textsuperscript{90} HMOs also pull patients away from fee-for-service physicians (private practice MDs).

Should an HMO enrollee require hospitalization, the HMO contracts with one hospital at a reduced or discounted rate. The hospital makes money, but not as much as it would make with a non-HMO enrolled patient. That cause has brought about the effect of hospital-created HMOs;\textsuperscript{91} strictly a defensive move. The physician glut "stimulates formation of HMOs...."\textsuperscript{92} "The number of group medical practices has increased from 8,483 in 1975 to 15,485 in 1984 with the rate of increase accelerating rapidly since 1980. There were 140,392 physicians or approximately 26 percent of all doctors,
The competition of private practice is too much for recent medical school grads. Therefore, a group practice, i.e. HMOs, is more practical. The fewer physicians available, the fewer admissions to hospitals since private MDs are the source for most hospital admissions. A 1985 survey indicated that 47.3 percent of consumers depended upon a physician to select a hospital.

Do HMOs decrease the cost of health care? Many believe so.

A University of Houston professor believes HMOs decrease health care costs. Dr. Jack Harold Upton Brown stated in his book, *The High Cost of Healing: Physicians and the Health Care System*, "HMOs ... have been the first break in the long chain of higher hospital costs and more expensive medicine." Nearly two-thirds of all major U.S. corporations offer HMO benefits to employees. The government is also convinced HMOs will decrease federal health care expenditures. "HMOs [have] demonstrated [the] ability to offer the elderly more benefits per Medicare dollar through a tighter rein on hospital use...." The TEFRA legislation "authorized Medicare to negotiate ... contracts with HMO's." Said Secretary Heckler in the *New England Journal of Medicine*: "[HMO contracting for Medicare patients] can translate into long-term savings for the Medicare program." She also predicted up to 600,000 Medicare beneficiaries will enroll in HMOs over the next three to four years. However, not all, including the elderly, are sold on HMOs.

According to Robert L. Dilenschneider, president of Hill and Knowlton, the elderly regard HMOs as "low-quality health care." Dilenschneider
presented a speech on "Ethics in Health Care Marketing" to group from the American Medical Association.

With more doctors joining group practices, i.e. HMOs, one physician in Texas believes, "Doctors [will] become the hired hands of giant corporations [and] will worry more about saving dollars than saving lives." Some physicians in Texas, California, Hawaii, Florida, and New York are fighting HMOs. One Los Angeles doctor, contracted to an HMO, said he was concerned about his inability to provide adequate care for patients. James Orlikoff, director of the American Hospital Association, concurs with these doctors. "HMOs have an economic incentive that may pressure them (both doctors and hospitals) to undertreat patients."

A study by the Rand Corporation found that indeed HMO-type medical plans do keep healthy people healthy but also let the poor and ailing get sicker. The study, funded by the Department of Health and Human Services, found "HMOs ... in general, may be predisposed to under-serve ..." The question for pro-private practice advocates is: Does this underserving belong exclusively to HMO plans? Probably not as non-HMO insurance plans are beginning to follow HMO utilization criteria.

HMOs are beginning to lose the trust of big business, too, because "HMOs are going to the bank with the corporations' money" and "many benefits managers do not think HMOs are saving (the corporations) money."

The Joint Commission on Accreditation of Hospitals (JCAH) is concerned about monitoring HMO quality. Hospitals are frequently reviewed to assure the delivery of quality care, however there is not such an organization for HMOs. Providers of health care have "economic incentives NOT to provide
services..." With these incentives and with Medicare policies encouraging beneficiaries to join HMOs to reduce expenditures, could the accusations of the nation's physicians be true? True or not, "HMOs are the wave of the future..." 109

Diagnosis related groups, health maintenance organizations, preferred provider organizations, "7-11 medicine,..." all are affecting hospital occupancy rates. Declining rates beget declining revenues. Declining revenues beget hospital closures. Hospital closures beget... an attempt at a cure.

"Hospitals are most anxious to find a remedy for inadequate reimbursement and capricious utilization patterns...."110 Hospitals must now swallow a strong dose of medicine as a curative agent--a case of hospital, treat thyself. What is that treatment, and will it work?

Summary

The government had the right idea, but it instituted a system without first looking ahead or, as a business analyst would say, without performing basic marketing research. As a result of government shortsightedness, billions of dollars were exiting government bank accounts and entering hospitals' bank accounts.

Congress wanted to stop the flow of dollars and enacted numerous provisions to do so, but with every attempt, Congress changed the health care industry albeit inadvertently. The best money-saving tactic was TEFRA or the Tax Equity and Fiscal Responsibility Act. TEFRA and its reimbursement system created a panic among health care providers (hospitals). The changes
TEFRA provided satisfied the government, saved money and forced changes in the health care industry. Not all providers were in tune with those changes and many more do not now even recognize those changes. Hospitals have four options (explored in Chapter 2): change, stagnate, sell out, or close. What options are hospitals choosing? All four, but those willing to accept the changing health care environment are better able to care for patients and can hopefully, better handle resources.

Chapter six looks at what the future should (may) hold for hospitals in Riverside, California, in California, and in the nation.
Chapter Six Introduction
The Future of Health Care

Changes in the health care industry are inevitable. Prior to the 1980s, there wasn't much change. Health care's future is as intangible as its products. The unfortunate aspect of the industry is its unpredictability. An uncertainty exists about what the federal government is going to do next, and that is keeping the industry unsettled. However if hospitals can create scenarios to predict some of those changes, then hospitals might be able to influence those changes to a more favorable conclusion instead of "backs to the wall" and ultimate closure.

The State of California is keeping health care providers off balance, too. What is the state of Medi-Cal? The governor and the legislature continue to do battle with the poor, the doctors, with the hospitals in the middle. Some predict a total revision of the Medi-Cal system, yet others don't believe any changes will be helpful to Medi-Cal recipients or to doctors and hospitals.

Riverside has several factors which will affect its hospitals--the opening of one and possibly two new hospitals; growing HMOs; city and county growth, and the support or lack of support of marketing.

This chapter also presents more basic marketing techniques, which if used a few years ago, could have assisted hospital administrators better prepare for the changes in the health care industry. It is easier to look back then to look ahead, but looking ahead can alleviate looking in the want ads for jobs.
Chapter Six
The Future of Health Care

The question is not, "Will there be a future for health care," but, "What kind of future will it be?"

Riverside’s health care providers don’t believe they will be "up against any walls." Said Dr. Lansing from Parkview:

"Riverside has a good outlook because the population will continue to increase. I think we might see hospitals specialize in certain areas of health care like obstetrics or general surgery or cardiac care. We’ll all try to carve out a ‘niche’ by decreasing some services while increasing others."¹

In an article done by Patricia Barnes of the Riverside Press-Enterprise, Lansing said Parkview anticipated the crunch and had adequately prepared for it. "That’s the reason I think we’re going to survive OK."²

Steve Hartert of Community agrees with Lansing’s "niche" philosophy:

"There will be a networking effect. Hospitals will be working together referring from one specialty hospital to another. Hospitals are not all things to all people and, although [hospitals] are fighting each other now for patients, that won’t continue. Communities are not any better served."³

The networking theory might be idealistic but hospitals will probably be held more accountable for their policies and practices. "Health care will be consumer-driven and consumers are going to demand that quality care increase while costs decrease," Hartert said.⁴ Lansing and Hartert agree that health care must decrease the waste and the attention to non-productive items. "The more educated the consumers become, the more they are going to seek alternate care options."⁵
Those alternate care options are steadily growing in Riverside. The Riverside Medical Clinic, once a room at the famed Mission Inn, is now a block-long complex with over 70-affiliated physicians and a staff of nearly 400. The clinic has branch facilities in other areas of the city and Riverside County. The reason for the continuing expansion is in "response to demands by government and the insurance industry to keep medical costs down." According to the clinic's administrator, Kenneth Marcoux, "Patients who used to go to their private physicians now come to [the clinic] because that is what their insurance company will pay for." The clinic has several health maintenance organization (HMO) contracts including Health Net, PacifiCare, and Maxicare and more than 85,000 of the clinic's patients are enrolled in an HMO.

The Riverside Medical Clinic has a facility in Moreno Valley, the sight of a newly-proposed hospital. The clinic, jointly with Riverside Community Hospital, is examining the feasibility of erecting that city's hospital as is Parkview Community Hospital and Hemet Valley Hospital. (Hemet is located approximately 60 miles from Riverside.) The Hemet hospital has made the most progress and has already proposed building a 300-bed hospital. Which ever entity wins the City of Moreno Valley's approval, all other neighboring hospitals will feel a decline in patient utilization. There are currently 73,000 people in Moreno Valley with projections of upward to 200,000 by the year 2000. The City of Riverside's population is now at 200,000 and has two private and one county hospital located within a 10-mile radius of each other. When Kaiser opens its Riverside facility, there will four hospitals...
within that 10-mile radius. "When Kaiser opens, it will hurt us," Lansing said. 9

Riverside Community Hospital views the future in direct contrast to the way Parkview Community is looking at the future. Community's focus is mostly inward, trying to meet community needs and to accommodate its service area, by restructuring its service. The most current structure changes have occurred in maternity and cardiac services, plus innovations in eye care and community outreach ("wellness programs"). Parkview is doing some in-house changing, but has taken on a burden to reach the community where that community is located, having purchased several private physicians' practices in attempting to establish out-patient clinics in outlying areas. Improved in-patient services and satellite out-patient services are different approaches to what these two hospital administrations believe are the trends in California and in the nation.

California

Governor Deukmejian wants to impose more cuts on the state's Medi-Cal (Medicaid) budget to keep the state from experiencing deficit spending. The state's legislature has voted to reinstate some of the monies the governor had already cut. The score: Deukmejian 1, for his immediate 20 percent cut, and the legislature 1, for reinstating other cuts in Medi-Cal services. Where does this haggling leave the Medi-Cal system?

Unfortunately, there really is no answer. "This back and forth system can't continue," Lansing said. "The state's indigent care system is poor at best, and the costs are being inflicted upon hospitals, doctors, and third-
party carriers. It's a burden we're all forced to carry. When it comes to predicting what the government is going to do, no one really has a true grip on the answer. Look for sweeping reforms on both the state and federal levels in the Medicaid program. There will be cuts in services and many, both deserving and undeserving, will be eliminated from the program. Also look for a DRG-type attitude to Medi-Cal's reimbursement system. This might discourage more hospitals from negotiating Medi-Cal contracts unless the reimbursement system proves to be less rigid than the Medicare system. In the meantime, while California's governor and the legislature fight amongst themselves, the poor will continue to seek medical care and the hospitals will continue to have mounting uncollectable bills.

**The Nation**

Is national health insurance or socialized medicine possible in the U. S.? Debate continues on the subject which was first brought up in the 1940s. Would it work in this country? Michael Harrington, co-chair of Democratic Socialists of America, said in USA Today. "If ever there were a system (health care) which needs basic restructuring, this is it, yet . . . we are told we cannot afford to do that." The debate remains.

Health care will change as the government wants to change it, that has been shown to be historically true. Continued reforms by Congress in Title 18 (Medicare/ Medicaid) will keep hospitals on an uneasy ground. Said Community's Dalton:

"The number of entrants into the market has not gone down [neither] has the number of available beds and yet the number
of patients available in the market has [gone down]. Meanwhile, reimbursement has tightened so, given that scenario, yes [the future of hospitals could be bleak]. Hospitals are looking at ways to find new business or [to] control a different element of the dollar. [If] hospitals can be tied into the distribution system [of patients] . . . revenues would not [be] based on filling beds but maybe on keeping the bed empty."

In other words, hospitals should be investing in a part of the patient distribution system i.e., HMOs, out-patient facilities, so revenues would not be solely based upon in-patient business. Hospital that create an HMO or invest in an HMO system can make money on the trends of out-patient services. Is that the trend for health care? Many believe so. Any system perceived as saving revenues for the consumer, business, and the government will be utilized more and more.

Attempted Conclusions
For this study, only questions about health care's future were available in the resource material. There were no concrete answers. Presented were trends: HMOs and PPOs, "7-11 medicine," a physicians glut; statistics: occupancy rates, dollars spent; facts: Title 18, DRGs; but no solid predictions --more like prophecy. Prophecy is usually conditional, if this continues, then this will happen. Maybe attempting to predict the future, especially when that future involves the government, is something no one dares do. The government's good ideas of the past have proven, in many cases, to be the nightmares of the future.
Thus, drawing a conclusion to this study is difficult. The changing environment of regulation, the economy, health issues et al, make a single conclusion almost impossible. That inability to predict the future can act as an excuse for hospitals to not try to predict what will happen. What is not difficult to predict, however, is the continuing federal, state, and local government tiring, tiring of investing resources into health care. Sources "predict" more reforms are in store for this teeter-totter industry. The industry can no longer be reactive, but instead should be proactive. Taking a proactive role means influencing the environment not just reacting to it. Marketing encourages a business to be proactive and not to sit back and wait for something to happen, then react.

The ability to anticipate environmental changes is a part of marketing. The study of the environment includes identifying opportunities and threats and then posing questions that will affect success in the industry. Key factors in examining the environment are technology, demographics, government, culture, and economics.

Technology has contributed to a large portion of competition hospitals are now experiencing. Medical advances have sustained the entrepreneurism of the freestanding emergency clinics, surgical and birthing clinics and, has given rise to portable computerized tomography (CT) businesses. More and more advances in medical technology place burdens, some too heavy to carry, upon hospitals. Many communities expect hospitals to have the latest "gizmos" for detecting and/or curing diseases. Hospitals need to be penny foolish and pound wise when purchasing the "latest" technology. A study into the life cycle of technology would give clues as to
whether one innovation is in a decline or growth stage. For example, CT scanners were introduced in the early 1970s. Advances in that field have made this technology a viable entity. Hospitals waiting too long to purchase CT equipment have lost dollars and possibly some credibility in the community. Yet the purchase of such equipment now might be unwise as CT scanners are entering the maturity stage and new technologies may soon be replacing the CT. A new diagnostic tool, magnetic resonance imaging (MRI) is in the introduction and growth stages and may soon displace CT as the diagnostic tool of choice. A complete marketing study of both industries may save a hospital investment dollars into an old system (CT) or in a system which may not grow as predicted (MRI).

Demographics, as outlined in this study, are changing. The nation is getting older. An examination of this aging nation may help hospitals cut or expand current services to meet these changes. Example: wellness programs for seniors, investments in Medicare plans for seniors, hospice or geriatric care programs, investing into post-hospital care facilities, starting home health care for seniors, etc.

A demographic study can lead to marketing services for individuals making health care choices. Women are being targeted by some hospitals and HMOs as the prime mover in making the choice of doctor, health plan, hospital, etc. With the rise of single-parent families and the two-adult worker households, this philosophy may be advantageous and prosperous.

Maybe the hardest environmental factor to examine is governmental, yet most legislative moves are telegraphed long before each happens. Then, after a law is passed, some have delayed enforcement dates, or sunset
clauses. A study of the government environment is a key to survival in the health care industry. A study, conducted today, would reveal proposals to further trim Medicare expenditures. The Congressional Budget Office is proposing the prospective payment system (PPS) rebase payments on the 1984 actual cost data. This would result in a 7.7 to 10.1 percent payment decrease for urban hospitals. A proactive approach would take the form of intense lobbying to reveal the dangers of those proposals to health care. Another proactive approach, from a marketing standpoint, would be to create the "what if" scenarios.

Typically, three scenarios are developed: optimistic, pessimistic, and the most likely. Institutions set up plans based upon "what if this happens," taking into account the optimistic and pessimistic approaches. Both approaches are then picked apart with the most likely occurrences placed into the most likely scenario. Strategies for this scenario are mapped out as are back up or contingency plans for other environmental possibilities. "What if the government reduces our payments by 10 percent?" Answering that will help construct a proactive approach to changes in the environment instead of a reactive approach. Reacting to changes instead of anticipating changes often results in crisis management and hastily made decisions which often end up costing too much.

Cultural environmental changes were ignored by hospitals until recently. The 1970s and 80s have produced sweeping attitude changes in diet, fitness, and quality of food. The majority of hospitals missed numerous opportunities to "sell" programs to the community on how to exercise, how to stay fit, how to eat, etc. The "wellness programs" hospitals are now
sponsoring should have rooted earlier. (Analyze the food patients and hospital employees are served from hospital cafeterias. One can pretty much predict that high fat and high cholesterol foods will be the mainstay of hospital menus. Changes in serving patterns and menus is an in-house marketing tool too often neglected.) Had hospitals been a part of these changes, the patient base may have increased because of a higher consumer awareness. Hospitals may have had a chance to beat the fitness chains and could have opened a community exercise and fitness center.

Economic factors are another difficult environment to anticipate, however certain trends are frequently forecast. Analysis of unemployment, inflation, economic growth, and interest rates are part of that analysis. Based on these rates, hospitals could assess the best time to borrow money for expansion or for cutting back or to predict occupancy rates and prepare for that crunch. Too simple? Maybe, yet not going through these processes lessen the chance of failure.

Customers Make Intangible Products "Tangible"

Health care remains an intangible product, however defining the product is made easier through consumer perceptions. These questions should be asked when emphasizing the consumer:

- Who are the buyers and users of the product/service?
- Who are the largest buyers?
- What potential customers can be identified?
- What motivates customers to buy and use the product/service?
- What attributes of the offering are really important?
• What objectives do the customers seek?
• What customer motivation changes are occurring or likely to occur?
• Are customers satisfied with the product/service they are buying?
• Do customers experience problems?
• Are there unmet needs?13

These questions define the product, the need for the product, who's buying the product, what groups are not buying it, why the product is being purchased, what the product's benefits are, and are there any problems with the product? The answers help to formulate changes or reinforcements in future marketing strategies.

Adopting to the New Business

The buzzword for this decade is marketing,14 and on that premise, new business is built. The new business has customer service as policy. Hospitals must adapt to increase a customer base, and to retain those customers already buying the product. Evidence, however, demonstrates that hospitals are slow in accepting this concept.

Marketing is a slow process. It's developing a philosophy and goals and objectives; it's predicting the environment and acquiring information about that environment; it's analyzing consumer need and breaking down which consumer segment best fits the product; it's developing strategies and objectives for the "plan of attack;" it's pricing and promoting a tangible product, and finally, it's analyzing consumer response toward the product. Marketing is not promoting or advertising what exists. It is a carefully planned process.
Yet in order for external marketing efforts to be successful, effective internal marketing must be initiated. The front line people--those who answer the phone, meet the customer, prepare the bills--are the "moment of truth" in any business. Neglecting the training of these individuals can be the downfall of any business as customers have too many options available to them to tolerate customer mistreatment. A hospital's marketing plan, encompassing all the externals, should include training programs in customer relations for those responsible for the customer's first and last impressions.

If and when hospitals adopt the attitude of customer importance and if and when hospitals begin comprehensive marketing programs, chances of being "backed against the wall" will diminish and the predictions for 1990 will be but a prophecy of "What if hospitals don't...."
APPENDIXES

PARKVIEW COMMUNITY

Drg Worksheet

Patients Name- [REDACTED] Age - 74 Sex - M R + B - 1987

Patient Number- [REDACTED] Medical Record No. [REDACTED] Financial Class 0100

---- NOTE TO PHYSICIANS ----

Drg will be computed based on information from the record on the first working day following admission. Drg will be recomputed at intervals as additional diagnoses and procedures occur. Please make corrections/additions/deletions as needed:

<table>
<thead>
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<th>Principal Diagnoses</th>
<th>ICD-9-CM</th>
<th>MD -- Check One</th>
<th>Physicians</th>
</tr>
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<tbody>
<tr>
<td>* Atelectasis</td>
<td>5180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P Pneumonia, Organism Nos</td>
<td>486</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Respiratory Failure</td>
<td>7991</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>3 Acute Renal Failure NOS</td>
<td>5849</td>
<td>*</td>
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</tr>
<tr>
<td>4 CHF Airway Obstruct NEC</td>
<td>496</td>
<td></td>
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</tr>
<tr>
<td>5 Gastrointestinal Hemorrhage NOS</td>
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<tr>
<td>Hyperglycemia</td>
<td>7906</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Infiltrate</td>
<td>5183</td>
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</tr>
</tbody>
</table>

Principal Procedure

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P Temporary Tracheo 311

Other Procedures

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105
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We're in a family way!

Riverside Community Hospital and our physicians are announcing a very special event. An entire wing of the hospital is being devoted to a new family-centered approach to maternity care. We're proud of our new "baby" and we're naming it "The Family BIRTHplace at Riverside Community Hospital."

The Family BIRTHplace will offer you quality hospital care in a comfortable, well-equipped, private birthing room that looks and feels like home. Labor, delivery and recovery all take place in your room and can be shared by the father. And special visiting hours allow grandparents and siblings to see and hold the new baby as soon as possible.

The Family BIRTHplace at Riverside Community Hospital will offer a variety of birth options to choose from that are based on your length of stay. In all, it's a very personal setting for birth with the security of full medical backup if needed.

Just like your baby, our "baby" is going to take about nine months to develop properly. But we'll continue to let you know about our progress. Our Maternity Teas are held regularly so you can find out more about your stay at Riverside Community Hospital.

If you need a physician, or if you have questions about The Family BIRTHplace, just call our special hostess at (714) 371-BABY. Monday through Friday, from 8:30 until 4:00.

Services of The Family BIRTHplace at Riverside Community Hospital

- Prenatal care classes at two convenient locations
- Gourmet meals
- Special price packages
- Maternity Teas

Call The Family BIRTHplace hostess for information.

Call (714) 371-BABY.

The Family BIRTHplace at Riverside Community Hospital

Dad
"We're starting to show!"

To help you in choosing The Family BIRTHplace at Riverside Community Hospital, prospective parents are invited to be our guests at a special BIRTHplace Preview where you will be able to tour our facilities and learn about our maternity services. Although we are currently remodeling the rooms and nurseries, conventional deliveries, cesarean births, and family birthing experiences are all now available at The Family BIRTHplace.

Five private Labor-Delivery-Recovery (LDR) suites will be ready by spring, and Family Suites will soon follow. The rooms will be furnished attractively, very much like a bedroom at home. You can have your baby in a home-like setting with the safety and security of the hospital. Each suite contains sophisticated lifesaving equipment.

The Family BIRTHplace has two special nurseries to take care of your baby's needs: a Well Baby Nursery for the times your baby will not be with you in your room, and a highly sophisticated Special Care Nursery—in case your baby has special medical needs.

Our approach to family-centered maternity care emphasizes the family unit from the very beginning. If you need a physician, have questions, or would like to be our guest at The Family BIRTHplace Preview, just call our special hostess.

CALL (714) 371-BABY

The Family BIRTHplace
at Riverside Community Hospital
4445 Magnolia Avenue • Riverside, California 92506

Services of The Family BIRTHplace at Riverside Community Hospital
- Special BIRTHplace Preview
- Special price package
- Infant CPR & safety
- Maternity lab
- Prepared childbirth classes
- Care classes
- Flexible visiting hours
- at two convenient locations
- Gourmet meals
- Physician referral

Monday through Friday from 9:30 am until 4:00 pm
If long distance, call collect.
Wishing You Holiday Health and Happiness

4445 Magnolia Avenue Riverside, CA 92501 714-788-3000
Act in your heart's best interest and call the HeartCare Program at Riverside Community Hospital for more information about:

- Physician Referral
- Emergency Care
- Preventive Education
- Cardiac Rehabilitation
- Home Health Care

To learn more about how the HeartCare Program can help you think for your heart, clip and mail the coupon below, or call the one number you ought to know by heart.

Call 68-HEART (684-3278)

I'd like to learn how to think for my heart. Please send free information.

NAME
ADDRESS
CITY, STATE ZIP

Clipped and mailed to The HeartCare Program Riverside Community Hospital 4445 Magnolia Ave. Riverside, CA 92501
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