

Diversification: Broadening Hospital Services: What Makes Sense?

Hospitals Magazine (December, 1982): 68-73.

Not all pathways to diversification are best for all hospitals. Hospital administrators and boards can minimize risks by analyzing markets and leveraging resources they already possess.

As the hospital industry enters the second decade of maturing demand for its key services, administrators and boards face significant new challenges. Major changes are taking place in health care reimbursement that will put new economic pressures on hospitals. Departure of federal and state health care programs from cost reimbursement, and responses to mounting underwriting losses (estimated at \$2 billion in 1981) by those private insurers who pay hospitals at rates exceeding cost, threaten the profitability of hospitals' traditional services. Even without Congressional "help," the private sector, through alliances and business coalitions, seems to be moving toward brokered or negotiated frameworks for purchasing health services.

At the same time, hospitals face a maturing market for inpatient care. Demand for inpatient services over the last 11 years has grown at only 40 percent of the rate of the previous 15 years, despite the increased aging of the population. Hospitals are losing their monopoly on many of their most profitable forms of care, notably surgery and diagnostic services. They face growing external competition from new forms of care controlled by physician entrepreneurs, as well as increased fiscal pressure to discharge patients sooner into aftercare settings. With less seriously ill patients directed into settings other than inpatient placement, patient acuity, and therefore the cost of treatment, are likely to be driven upward at the same time as those who pay for health care are stepping up efforts to contain hospital costs.

As a result of these pressures, hospitals face the prospect of significant, further erosion in the market for services they traditionally have rendered, as well as declining liquidity and profit margins, in the coming decade. Hospital administrators and boards have begun to respond to these challenges by following the path of other maturing industries in seeking to diversify – that is, broaden their mix of products or services. The objectives of diversifying beyond the conventional inpatient acute care and outpatient services that hospitals have delivered in the past will be discussed.

Diversification of a hospital's product holds the key both to controlling a hospital's market position and its long-term economic viability. Yet, the process of diversification contains significant risks. These inherent risks have been heightened by the fact that many hospitals have entered into the process pell-mell, without careful analysis of markets, economic benefits, and costs. Not all pathways to diversification make equal sense for hospitals, economically or programmatically.

If hospitals wish to remain providers of inpatient acute care services, they must take steps to secure their position in tightening local or regional markets for inpatient services. As many of the nation's Blue Cross Plans are discovering, allowing one's marketshare to slip

in a maturing or declining market is a recipe for impending bankruptcy. Therefore, one of the primary objectives of diversification should be to strengthen a hospital's "product line" in order to secure, if not increase, its share of the inpatient market in its service area. Diversification strategies should seek to extend a hospital's sphere of influence, directly or indirectly, to activities that may lead patients to seek hospital services at some future time. Through direct ownership and management, or joint ventures with physicians and other participants, hospitals are developing feeder networks that provide a wide range of ambulatory medical services antecedent to inpatient care. Many forms of health care delivery – including both traditional physician office-based care and newer forms of care delivered in freestanding emergency and diagnostic centers – can serve to filter patient populations in order to identify those needing hospital-based specialty care, diagnosis, or treatment.

At the same time, hospitals are developing new services that follow patients after discharge to assure continuity of care through recuperation. Hospitals thereby also assure that any incidents requiring rehospitalization will result in patients returning to the original hospital instead of a competitor's. Though severe economic uncertainties in the nursing home industry do not bode well for hospital integration into inpatient chronic care services, hospitals have begun to offer a wide range of ambulatory and in-home services for the elderly and chronically ill at significantly less economic risk. Besides meeting critical needs, hospitals are discovering that provision of these aftercare services can relieve physicians of the need to render nonmedical services to the recuperating patient, and help provide coordination of the bewildering array of alternative services directed to the important population. By linking both prehospital and post-hospital services to the traditional inpatient services of the hospital, hospitals not only are meeting new community needs but also are securing control over their inpatient utilization by "organizing" both entry and exit from the hospital.

The other principal objective of diversification should be to generate new capital for replacing the plant and equipment and to keep pace with changing medical technology. Several recent analyses have demonstrated that anticipated demands for capital in the hospital industry over the next 10 years outstrip the availability of capital from traditional sources. Government grant support for hospital construction has largely evaporated and the contribution of philanthropy to hospital capital has sharply diminished over the last 10 years. The latter contribution is expected to diminish further through recent changes in the federal tax code that reduce tax-related incentives of philanthropy for donors.

Hospital profit margins, never large by conventional business standards, are likely to be eroded by Medicare and Medicaid cost-containment measures and the movement of charge-based payment systems to brokered or negotiated rates. For these reasons, hospitals will be hard-pressed to internally finance capital needs from retained earnings to the extent they do now. Debt has been the principal source of hospital capital for the last decade. Outstanding hospital tax exempt debt has tripled over the last eight years from \$10 billion to more than \$30 billion, even in the face of escalating interest rates. It is uncertain whether debt markets will sustain another tripling in hospital indebtedness in

the next eight years. Questions remain among Administration and congressional health policymakers about continued access by hospitals to tax-exempt credit markets.

To meet their capital needs, hospitals must generate the new capital that they will be unable to produce from inpatient care due to cost-containment pressures. Hospitals are experimenting with ways their managerial and technical competencies can be used to sell products and services in new markets. Hospital managers are discovering that many of their departments, such as food services, housekeeping, pharmacy, computer services, radiology and clinical laboratory services, and general management, can serve many clients outside their hospitals, thereby earning new revenues.

Hospitals also are discovering profitable new patient care markets such as home care, ambulatory surgery, substance abuse, sports medicine, and stress management. These new ventures can assist a hospital in leveraging its capital and resources to generate new streams of income while meeting unmet community need. (A more detailed discussion of some of these diversification opportunities may be found in Kernaghan's article in this issue, page 75).

There is a danger that some hospitals will pursue the diversification process in a poorly planned, uncoordinated way. Risks are involved in entering any new business. Hospital boards and administrators can minimize these risks by making intelligent, data-based choices about how to allocate their hospital's resources, rather than responding ad hoc to opportunities that arise. In thinking about diversification opportunities, hospital boards and administrators should try to answer the following questions geared toward broadening a hospital's product mix:

1. *What is the market for a new product or service and who are likely competitors?*

Despite the seemingly simplistic nature of this question, it is amazing how little formal market analysis is conducted by some organizations before launching a new venture. Yet, offering a community a product or service in a market already crowded with established, well-capitalized competitors is a recipe for rapid failure. Taking one's food service into the commercial-events catering business may not be a good strategy if existing caterers are scratching for business. Integrating "backward" into manufacturing I.V. admixtures or surgical supplies may seem like an interesting idea in theory, until one ponders the fact that it could mean swimming into the jaws of some well-organized, aggressive marketing organizations, such as Baxter Travenol and American Hospital Supply.

If substantial organizations like Hospital Corporation of America are unwilling to integrate backward into medical supplies or equipment, how much sense does it make for a regional or community hospital to do so? A rigorous analysis of market demand and competitor characteristics should be the first step in any diversification process. Boards of trustees should not be satisfied with bland assurances on matters of market feasibility. They should demand hard copy – facts and numbers – from their administrative team before committing resources to new ventures.

2. *Is an opportunity consistent with a hospital's mission?*

This question presupposes that a hospital has a clearly defined mission. The absence of a statement of mission deprives the board and administrator of a consistent framework for action. Further, the lack of a clearly defined organizational purpose makes the hospital prey to constant redefinition of its program as each new opportunity arises.

Given that a hospital does have a clearly defined mission and purpose, opportunities to diversify or enter into new business should be evaluated in terms of their consistency with the mission. For example, it may be difficult for a hospital strongly rooted to serving one community to justify development of a multi-state network of contract-managed hospitals. Similarly, it may be difficult for a teaching hospital strongly committed to serving the inner city to justify development of a network of freestanding emergency facilities in the suburbs. Diversification that is inconsistent with a hospital's mission and goals can dilute a hospital's sense of purpose and lead to image problems and troubled relations with long-standing patient, physician, and community constituencies. These bases of support are a major resource to a hospital in a tightening market and should not be frittered away.

3. *What impact will pursuing an opportunity have on a hospital's capital position?*

Hospitals have the disadvantage of being both capital and labor intensive. They share with most capital-intensive industries a very low rate of return on their capital. In looking at alternative uses of capital, hospitals must develop strategies to leverage existing capital to generate as much cash flow and net income as they can, all other things being equal. The capital requirements of entering a new line of business and the projected rate of return on that capital should be major factors in the diversification decision.

Maintaining a traditional, acute care services base will require enormous amounts of capital in the future, let alone efforts to keep hospitals current with changing medical technology. In developing new programs, hospitals should pursue patterns of investment that make them less capital intensive than they are now. At the same time, hospitals should recognize that resources devoted to new ventures are likely to be limited by capital demands associated with remaining in the inpatient care business. Low capital, high-margin diversification opportunities should have the highest priority. Capital should be rationed explicitly between competing potential uses – between continuing operations and new ventures – rather than allocated ad hoc as need or opportunities arise. The failure to plan comprehensively for future capital needs, and factor that planning into diversification decisions, could be fatal to many institutions.

4. *What contribution does a diversification opportunity make toward preserving a hospital's share of the inpatient acute care market?*

Not all diversification opportunities relate directly to the provision of inpatient services. Many forms of contract may earn money for a hospital without intersecting the flow of patients to the hospital. But for patient care-related diversification, an important priority should be to develop systems for capturing and controlling the flow of patients to and from a hospital. In thinking about these opportunities, a distinction should be made

between enterprises that divert business from the hospital market, such as freestanding surgi-centers and emergicenters, and those that feed a hospital, such as physicians' office buildings, mobile and remote site diagnostic centers, and transport systems. Both kinds of services have their place in a growing constellation of out-of-hospital service alternatives. But to the maximum extent possible, hospitals should attempt to deploy their resources in such a way that they are controlling and structuring the pathways into and out of the hospital.

Some diversification efforts actually may damage a hospital's inpatient market share by alienating key admitting physicians. For example, hospitals' efforts to diversify into ambulatory services through wholly owned facilities staffed by salaried physicians are likely to make serious resistance from hospitals' traditional sales force – private-practicing medical staff. Due to the sharp increase in physician supply in many parts of the country, medical staffs may face even more serious competition problems than hospitals do.

Strategies that harm the private practice base of its admitting physicians seriously will damage a hospital's market position. In developing new patient services outside a hospital, administrators and boards will have to experiment with new partnerships and relationships with physicians, so that physicians' loyalty and the viability of their practices are preserved.

5. *To what extent do opportunities enable a hospital to leverage human and technical resources it already has?*

Just as hospitals have not always been efficient managers of their physical capital, they have not always made particularly efficient usage of their enormous range of technical and managerial expertise. The degree to which new business opportunities relate to existing technical and managerial knowledge is an important variable in determining the likely success of a new venture. Historically, business did not diversity into areas completely unrelated to their core lines of business. In manufacturing, for example, companies learned to use by-products from their primary production process to make new products. Lumber companies learned to make particle board and paper out of by-products of the milling process. Automakers market odd lots of auto parts from their production runs to supply dealers and auto repairmen. American industry did not partake in conglomerate-style diversification, that is, corporate movement into large numbers of unrelated businesses, until the middle or late 1960s. Many of these experiments failed, resulting in divestiture and efforts to build an integrated base of related businesses.

The challenges of harnessing hospitals' technical and managerial resources into health-related enterprises are so enormous that diverting hospital management time and resources to learning non-health-related businesses may not be a wise decision. Hospitals should try to leverage the human and technical capabilities they already have. Geriatric day care is a good example of this leveraging process. Many hospitals have underutilized their outpatient departments, transport systems, social services, and nutritional staff, which all can be reprogrammed to deliver geriatric outpatient services. Not only do such services fill a need in the community, but they also provide challenging new career

opportunities for existing hospital staff. By furthering their employees' career development objectives, hospital administrators may ensure greater retention or experienced personnel. Much hospital diversification is likely to involve reprogramming and repackaging of resources hospitals already have. Hospitals should explore creative opportunities for reprogramming existing resources and people before moving into areas where they have little or no practical experience.

6. *To what degree do opportunities present frameworks for risk sharing with participants other than hospital management?*

Many hospitals have not been able to successfully encourage the entrepreneurial spirit and initiative of their medical and administrative staffs. Entrepreneurship is an important factor in the success of any new venture. In developing new business opportunities, hospitals may discover that they cannot secure the managerial talent or physician support to make the new venture succeed, without providing equity participation and profit-sharing opportunities to the participants. Many hospitals have created for-profit subsidiaries to foster diversification, because it is almost impossible to provide these incentives in a not-for-profit setting.

Diversification through wholly-owned and managed facilities and ventures has an important defect in a competitive market. Specifically, the hospital assumes 100% of the risk associated with the enterprise's success. Although this approach assures greater management control, it saps both managers and involved physicians of incentive to work the extra 10 to 20 hours a week, or to develop the bright new ideas, that may be necessary to make the venture succeed. To overcome these obstacles, hospitals will find themselves exploring new economic partnerships with physician and nonphysician investors and equity participation opportunities for both managers and physicians. These arrangements have an added advantage of leveraging hospital capital, bringing nonhospital equity into the ventures. However, the benefit of encouraging and rewarding entrepreneurship is as important as equity participation. Though it profoundly runs counter to some management traditions in voluntary hospitals, successful diversification is going to require rethinking of traditional economics, structures, and relationships.

Each hospital or organization probably will attach a different weighting or importance to the above-mentioned factors, depending on available resources, special capabilities, and other variables. But answering these questions in a systematic way may help minimize risks in handling new ventures and can provide an orderly framework for decision making.

Diversification away from its traditional institutional service base is not a risk-free endeavor for a hospital. Yet, it may be even more risky to cling to a definition of hospital business that locks a hospital in to the highest cost, least flexible market position in a maturing market increasingly concerned about price. Hospital planners, administrators, and boards have been told to believe that "the building is the hospital." In an increasingly competitive market we will come to view hospitals as collections of programs and services, technical competencies and medical knowledge, to be organized and distributed in a community according to its needs.

