UNTANGLING HEALTHCARE COMPETITION

Healthcare Managers Must Recognize The Three-dimensional Nature of Competition

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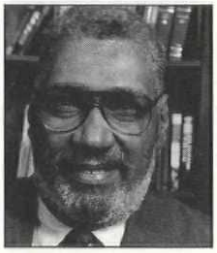

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With the rapid growth of strategic healthcare alliances, managers need a clear understanding of competition. If the competitive forces are misspecified, healthcare managers will have unrealistic expectations of alliance benefits. They will also fail to understand the environment within which the alliance will have to function.

Unfortunately, healthcare managers often misunderstand competition. Some even claim competition among providers does not exist. Although different from conventional definitions of competition, competition among healthcare providers does exist.

For Catholic providers, competition must encompass the concept of stewardship of resources to support activities that respond to needs and enhance services to people. This article does not specifically address these values issues; rather, it provides a perspective on how competition functions in healthcare to enable managers to formulate more successful strategic plans.

THE TRADITIONAL RESPONSE

Healthcare administrators often respond to competition using traditional market analysis and tactics, such as developing creative marketing, controlling costs, forming strategic alliances, or increasing staff productivity.

Generally, these conventional managerial practices are effective when appropriately applied, but they may create confusion and counterproductive activity in healthcare organizations. This is because conventinal practices might serve the needs of one critical stakeholder while failing to

Summary Traditional approaches to competition may be inappropriate for healthcare providers. Neoclassical economics makes the implicit assumption that a single actor embodies consumption, compensation, and benefit from a transaction. In healthcare, this assumption does not hold. Instead, such actions are accomplished by three separate actors—consumers (physicians), customers (third-party payers), and clients (patients).

A hospital simultaneously competes in three arenas. Hospitals compete for physicians along a technological dimension. Competition for third-party payers takes on a financial dimension. Hospitals compete for patients along a marketing dimension. Because of the complex marketplace interactions among hospital, patient, physician, and third-party payer, the role of price in controlling behavior is difficult to establish. The dynamics underlying the hospital selection decision—that is, the decision maker's expectations of services and the convenience of accessing services—must also be considered.

Healthcare managers must understand the interrelationships involved in the three-pronged competitive perspective for several reasons. This perspective clarifies the multiple facets of competition a hospital faces. It also disentangles the actions previously fulfilled by the traditional single buyer. It illuminates the critical skills underlying the competition for each audience. Finally, it defines the primary criterion each audience uses in sorting among hospitals.

Recognition of the multifaceted nature of competition among healthcare providers will help demystify market behavior and thereby improve internal organizational communication systems, managers' ability to focus on appropriate activities, and the hospital's ability to adapt to changing market conditions.

serve the needs of others. For example:

- Investing in medical equipment can drive costs up and weaken one's ability to negotiate with third-party payers. On the other hand, the equipment is needed to attract good physicians.
- Maximizing efficiency to strengthen bargaining power with third-party payers can backfire by alienating patients offended by "skimpy service."
- Locating in the heart of a metropolitan area to increase a hospital's convenience for patients may affect the hospital's appeal to physicians. Physicians may prefer the more plush, yet less populous, suburbs.

We believe that the confusion in these situations results from healthcare managers' misconceptions about competition. In response, we suggest a new way for healthcare managers to evaluate competition.

Hospitals' Unique Nature

Competition may be generally viewed as a collection of independent players or firms vying to satisfy buyers' needs. The question of whether competition is appropriate among healthcare providers has been actively debated for several years.[1] Much of the confusion is rooted in the unique competitive nature of healthcare institutions. Their anomalous characteristics lie primarily in three areas:

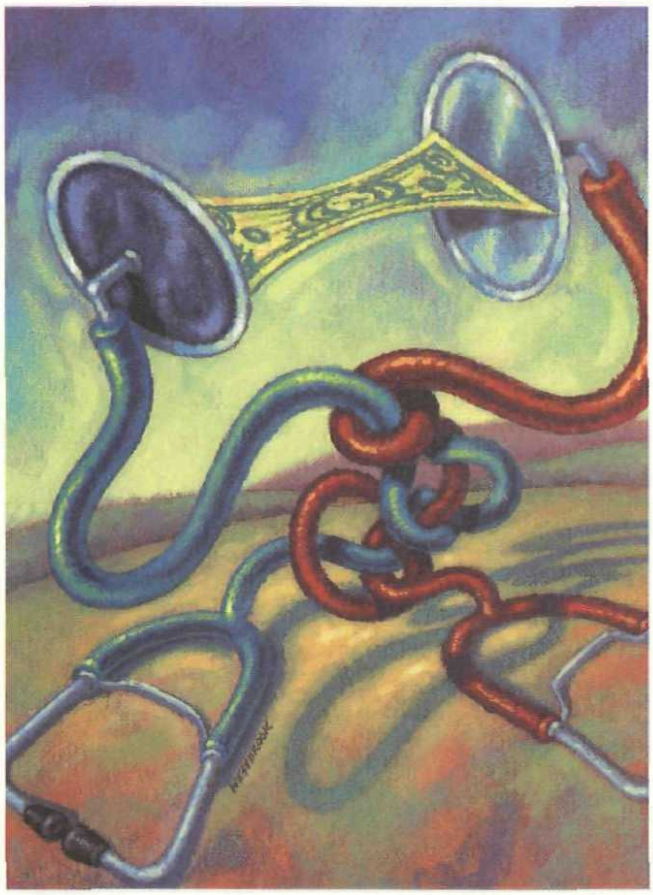
- Homogeneity of competition
- Simultaneity of consumption, compensation, and benefit
- Price as the coordinating device

Homogeneity of Competition Competition among healthcare providers is commonly thought of as being homogeneous across the range of markets. However, practices effective in one market can lead to poor results in another. For example, an urban hospital's clientele places a lower priority on access than a rural hospital's clientele would.

Simultaneity of Consumption, Compensation, and Benefit The conventional view of competition assumes a simple, straightforward exchange between a producer and a buyer. The traditional buyer performs three *simultaneous* functions:

- Consumption—the use of the product or service purchased
- Compensation—the payment offered to the producer
- Benefit—the satisfaction enjoyed due to the transaction

Neoclassical economics makes the implicit assumption that a single actor embodies consumption, compensation, and benefit from a transaction. In healthcare, this assumption does not hold. Instead, such actions are accomplished by three separate actors—consumer, customer, and client:



Eric Westbrook

- *Consumer:* Instead of offering medical services directly to the patient, hospitals offer resources (e.g., nurse support, medical equipment, and pharmacy services) to attending physicians. Thus one dimension of competition among hospitals is the competition for physicians (consumers).
- *Customer:* Hospitals are often compensated by third-party payers, or customers. Although a customer neither consumes nor benefits from hospital services, it directly negotiates payment for these services and has a direct interest in dealing with cost-effective hospitals. Thus hospitals engage in a second competitive arena—a contest for affiliation with third-party payers (customers).
- *Client:* Patients receive the most obvious benefit from hospital services and are thus the beneficiaries, or clients. Because patients have an influence on hospital selection—although possibly not as great as physicians'—hospitals tend to compete for patients by offering specialty ser-

vices, administrative professionalism, and up-to-date facilities. This is a third facet of hospital competition—for patients (clients).

Price as the Coordinating Device Perhaps the most significant consequence of the capital-based system is the pervasiveness of price as a coordinating mechanism. When producers seek to maximize profit and buyers (in the traditional sense) seek to maximize utility, the ensuing haggling in the marketplace results in an equilibrium where supply equals demand. Price is pivotal in this haggling or negotiation process (whether explicit or implicit). As a result, the emergent price often reflects buyers' preferences and producers' point of efficiency.

This system of thinking is inadequate for healthcare providers. Because of the complex marketplace interactions among hospital, patient, physician, and third-party payer, the role of price in controlling behavior is more difficult to establish. Therefore examination of price behavior (i.e., changes in price as a function of supply and demand) can result in misleading conclusions.

Hospitals simultaneously compete for physicians, third-party payers, and patients.

Hospital Competition Redefined

Before considering managerial or policy strategies, healthcare providers need a new definition of competition. Crucial to this reconceptualization are the dynamics underlying the hospital selection decision.

In general, two factors influence a decision maker's selection of a healthcare provider:

- The decision maker's expectation of services
- The "cost" of accessing the services

Depending on the relative dominance of these two factors, a hospital's approach to competition can vary widely. The level of services—and hence the buyers' expectations—will rachet up as competition based on services increases. Hospitals "raise the stakes" of competition by continuing to invest in new facilities and equipment so they can offer new and better services. Those choosing not to follow will fall behind their competitors in satisfying demand. But as the investment escalates, prices for these services will also go up.

In some markets, access costs may heavily influence hospital selection. Access costs refer to the complexity involved in using a hospital's services. Such costs include the expenditure of financial, emotional, or physical capital. Difficulties that arise because of the expenditure may be overcome by offering amenities such as sophisticated information systems, helicopter landing pads, and transportation from local airports. A hospital easily accessible to patients, physicians, and payers attempts to differentiate its services from those of its many competitors; a hospital more difficult to access may focus on offering a broad variety of services.

Competitive Arenas

A hospital simultaneously competes in three arenas. Acknowledgment of a three-pronged competitive perspective is useful in resolving the conundrum healthcare managers face when trying to reconcile the often contradictory demands of the environment. The following orientation should help managers assess the areas in which their hospital possesses comparative advantages. Naturally, such areas should be pursued while others are deemphasized.

Consumer Arena Hospitals compete for physicians (consumers) along a *technological* dimension. Accordingly, hospitals invest in new medical equipment and sophisticated facilities to attract the best physicians in the area.

Customer Arena Competition for third-party payers (customers) takes on a *financial* dimension. Hospital selection depends on a cost-benefit decision by the third-party payer. A payer acts as an intermediary to spread the risk of incurring healthcare expenses among a pool of families and individuals. To sustain this position, a payer's receipts must—over time—equal or exceed payments made to the hospital. This balance is reached by the payer increasing its pool of enrollees, raising premiums, or limiting reimbursements to the hospital. The emphasis differs among payers, but downward pressure on reimbursements is nearly always present. Hospitals are then left to compete by providing the payer with

the most cost-effective package possible.

Client Arena Hospitals compete for patients (clients) along a *marketing* dimension—most often related to patient comfort and convenience, either real or perceived. Availability of hospitals' services must be effectively communicated to clients.

Putting It All Together Healthcare managers must understand the interrelationships involved in the three-pronged competitive perspective for several reasons (see **Table**). First, the perspective clarifies the multiple facets of competition a hospital faces. It also disentangles the actions previously fulfilled by the traditional, single buyer. It illuminates the critical skills underlying the competition for each audience. Finally, it defines the primary criterion each audience uses in sorting among hospitals.

Implications

Misinterpreting hospital competition can have serious consequences for policymakers and healthcare managers.

Policymakers The faulty assertion that hospitals are incapable of competing may prompt policymakers to pass legislation that has a damaging effect on healthcare providers and communities. For example, governmental intervention to promote competition can be a waste of public resources because of the intense requirements for information. It is difficult to duplicate the efficiencies attained by the forces of the market, where self-interested parties bargain to a state of mutual satisfaction. The three-dimensional view of competition is vital to help policymakers recognize the appropriate occasions for and proper means of intervening in competition among healthcare providers.

Healthcare Managers The traditional view of competition, which implies that hospitals cannot compete, can be discouraging for strategic planners. The notion of strategic choice suggests that the competition will enable the most appropriate strategies to succeed. If the competitive "flurry" does not occur, then no arbiter exists to decide the "best" competitors. This may leave managers with the misconception that they do not possess the discretion to influence their destiny. They, like policymakers, may be led to believe that excessive government intervention is necessary.

Healthcare managers may focus on inappropriate areas of competition. Like all managers, healthcare administrators are subject to a perception bias based on their position and background. A one-dimensional view of competition leaves managers more vulnerable to this natural tendency. For example, a hospital may overspend on advertising and image when it is losing third-party payers. Or a hospital may cut costs to enable it to negotiate a bargain for a third-party payer but lose its physician base because it is no longer able to provide adequate technical support.

Recognition of the multifaceted nature of competition among healthcare providers will help demystify market behavior and thereby improve internal organizational communication systems. Clarification of constituents and their relationships with hospitals will also help direct managers' attention to the appropriate managerial activities, thus making better use of managers' time and facilities' resources. As healthcare managers focus on a facility's strengths, its consumers, customers, and clients are better served. This, in turn, enhances community benefit.

This new view of competition can serve as a useful diagnostic tool to interpret a facility's competitive context and any accompanying constraints. This enhances the hospital's ability to adapt to changing market conditions. Managers can systematically examine their facilities' envi-

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COMPETITIVE ARENAS

Arena	Action	Skills Used In Competing	Primary Criterion
Consumer (physician)	Consumption	Technology	Utility
Customer (third-party payer)	Compensation	Efficiency	Financial
Client (patient)	Benefit	Marketing	Convenience

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Pursuit of the low-cost strategy can mean disaster for a hospital.

ronment in hopes of retrieving valuable information early enough to effect appropriate responses to threats and opportunities.

PRESCRIPTIVE ADVICE

The use of textbook approaches to gaining competitive advantages in a typical manner may lead healthcare managers astray. For example, much of conventional managerial wisdom is built on the cost-benefit analysis. The common make-or-buy decision is a variation of this analysis. This concept underpins traditional competitive strategies regarding the outsourcing of all services too costly to handle internally. This economic-based directive assumes that a firm's production process can be easily disaggregated to minimize costs in each functional area. Such an assumption is ridiculous in the healthcare setting. Healthcare administrators must consider the interrelationships of many factors that do not lend themselves to economic analysis. Pursuit of the low-cost strategy can mean disaster for a healthcare institution.

Conventional competitive strategy also includes typologies to help managers organize their thinking and formulate competitive responses in the marketplace. One such popular typology is the Defender/Analyzer/Prospector/Reactor model developed by R. E. Miles and C. C. Snow.[2] Although healthcare institutions were used in the formulation of this model, its conventional use can exacerbate preexisting problems for healthcare administrators. The hazard in the use of this diagnostic system is the implicit assumption of a one-dimensional competitive prospective. Consideration of the three-dimensional outlook can result in apparently contradictory answers. But such contradictions may, in fact, be the most accurate assessment of a firm; that is, a defender profile may be apt in one area of the institution, whereas some other profile best describes another area.

In lieu of conventional competitive approaches, we recommend that healthcare managers begin with a three-dimensional competitive analysis, focusing on consumers, customers, and clients. Following this, traditional typologies and management theory can be useful, but with the vital caveat of *simultaneous* consideration of hospital strengths and weaknesses in *each* competitive arena. Resources should be focused on the strengths of an institution, but the goal should be an optimal mix of resource allocation among all three arenas. □

NOTES

1. A. C. Enthoven, "Managed Competition in Health Care and the Unfinished Agenda," *Health Care Financing Review*, Annual Supplement, 1986, pp. 105-119; D. E. Farley, "Competition among Hospitals: Market Structure and Its Relation to Utilization, Costs and Financial Position," *Research Note 7*, Hospital Studies Program, Department of Health and Human Services, 1985; R. Feldman and B. Dowd, "Is There a Competitive Market for Hospital Services?" *Journal of Health Economics*, vol. 5, no. 3, 1986, pp. 277-292; W. Higgins, "Myths of Competitive Reform, *Health Care Management Review*, vol. 16, no. 1, 1991, pp. 65-72; G. C. Pope, "Hospital Nonprice Competition and Medicare Reimbursement Policy," *Journal of Health Economics*, vol. 8, no. 2, 1989, pp. 147-172; M. Coyle, "Is Competition Compatible with Gospel Values?" *Health Progress*, March 1992, pp. 16-18.
2. R. E. Miles and C. C. Snow, *Organizational Strategy, Structure, and Process*, McGraw-Hill, New York City, 1978.

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to live and who was to die.

During the operation, the single liver and six-chambered heart the twins shared were taken from Amy and refashioned for Angela. When the shared heart was divided, Amy died. The operating team—six surgeons, four anesthesiologists, eight nurses, and one technician—did not pause to acknowledge the event. "We were aware at that phase what was happening," commented one of the surgeons. "But minutes really count, and you have to press ahead as fast as you can."

To see the ethical issue here more clearly, imagine a slightly altered scenario. Suppose that identical twins are born. They are not conjoined, but both have severe heart defects—each has a failing three-chambered heart. Doctors determine that both will soon die. But they offer one long shot. If the heart is removed from one child—not after her death, but while she is living—it could be used to repair the heart of the other. Wouldn't such a suggestion be rejected out of hand as a clear case of killing one patient to try to help another? Wouldn't such an operation be a clear violation of the parents' and doctors' duties to the child whose heart was taken? How different is this from what was done to Amy Lakeberg?

It is not sufficient to reply that the end justifies the means, that both twins would have died had Amy not been killed. Patients die every day, and we do not countenance killing others to buy them more time. Nor is it acceptable to say that Amy was not really a person because she shared vital organs with her sister. She had her own name, her own personality (reportedly the feistier of the two), and she was buried alone—all marks of an individual human person.

DOUBLE-EFFECT ANALYSIS

Can double-effect analysis avail in this situation? Perhaps the directly intended