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The Macromarketing Implications of the Entrance of For-Profit Firms in a Traditionally Non-Profit Industry: The Case of the US Hospice Industry

By

John J. Newbold, Ph.D.
Sam Houston State University

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Abstract

Reacting to changing social mores and an aging population in need of better alternatives for end-of-life care, the United States federal government permanently enacted the Medicare Hospice Benefit in 1986. At the time, the hospice industry was relatively small and dominated by small, independently-run non-profit organizations. However, the past 20 years has seen the hospice industry grow in exponential fashion, from less than 200,000 patients per year to a number that now exceeds 1 million patients per year. In addition, the pricing umbrella afforded by the establishment of the Medicare hospice benefit has attracted for-profit entities into this traditionally non-profit market sector. This paper discusses the higher-order societal implications of the entrance of for-profit firms into a traditionally non-profit market sector. Macromarketing impacts are discussed from the perspectives of dominant social paradigm (DSP) theory and exchange theory. Finally, areas for future exploration are set forth.

Introduction

As the US population ages, the need to find better ways of caring for dying people and their loved ones is becoming more acute. The hospice industry in the U.S. is a relatively small and fragmented component of the overall healthcare industry, generating aggregate annual revenues of about $4.5 billion in 2003. However, the growth in this sub-sector has been quite dramatic: Medicare spending on hospice care grew at a 13% compounded annual growth rate between 1995 and 2002, while aggregate patient volume grew at an 11% compounded annual growth rate between 1985 and 2002 (Shattuck Hammond Partners 2004). There are several factors driving this growth:

1) The overall aging trend in the US and the increasing size of the over 65 population.

2) The increasing role of advocacy groups in promoting hospice care over other end-of-life alternatives.

3) Favorable regulatory trends. The Center for Medicare and Medicaid Services (CMS), a Federal agency within the U.S. Department of Health and Human Services, appears to be promoting hospice care through its liberal policies for reimbursement, at least in part because hospice is viewed as a lower cost alternative to traditional, hospital-based end-of-life care.

4) Higher usage rates. Hospice care is being viewed as a more accepted and appealing alternative by doctors, patients, and families. This is particularly true for usage rates by non-cancer patients. (Shattuck Hammond Partners 2004)

Hospice care is defined by the Hospice Association of America as:

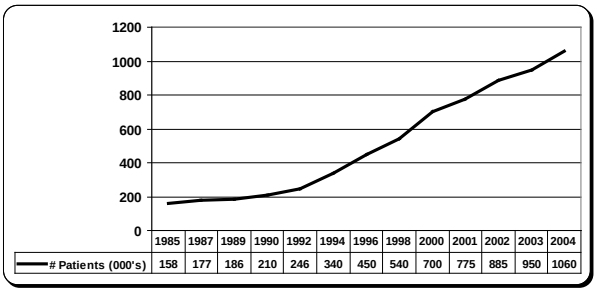
"…comprehensive, palliative medical care (treatment to provide for the reduction or abatement of pain and other troubling symptoms, rather than treatment aimed at cure) and

supportive social, emotional, and spiritual services to the terminally ill and their families, primarily in the patient's home. The hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family." (Hospice Association of America website 2005)

Palliative care differs from curative care in that its objective is to ameliorate pain and suffering, both physical and mental, as opposed to curing the patient of the illness.

In 1986, Congress permanently enacted the Medicare Hospice benefit. A significant jump in usage of hospices occurred at this time. Figure 1 depicts the exponential growth rate of patients choosing hospice services.

Figure 1: Number of Hospice Patients: 1985 – 2004 (000's)

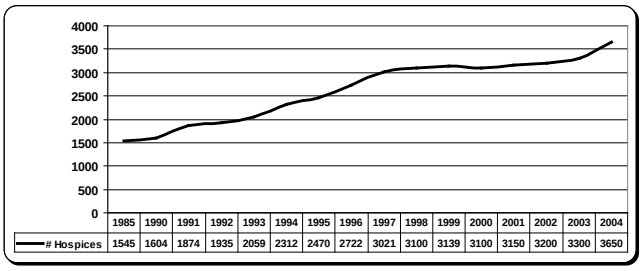


	1985	1987	1989	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004
# Patients (000's)	158	177	186	210	246	340	450	540	700	775	885	950	1060

(NHPCO November 2005)

In 1996, the federal government initiated a program ("Operation Restore Trust") focused on preventing Medicare fraud across all provider groups. This increased level of regulatory scrutiny, while probably needed, likely inhibited referrals of patients and reduced average and median lengths of stay industry-wide. The Balanced Budget Act of 1997 further negatively impacted reimbursement rates, further dampening the growth rate of hospice sites. Figure 2 depicts the growth in hospices between 1985 – 2004.

Figure 2: Number of Hospices: 1985 – 2004

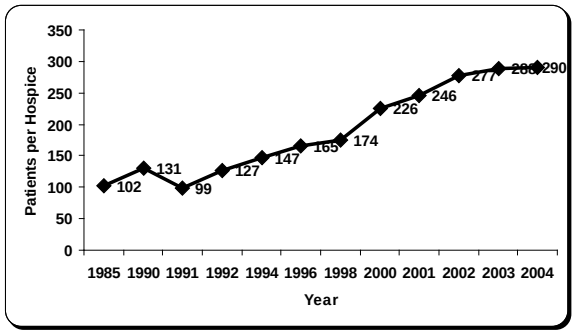


	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
# Hospices	1545	1604	1874	1935	2059	2312	2470	2722	3021	3100	3139	3100	3150	3200	3300	3650

(NHPCO November 2005)

The net impact of the ever-increasing number of hospice patients and the relatively flat growth curve in the number of hospice sites has been the increasing average size of the hospices in terms of patients, as Figure 3 below attests. Over the past 20 years, the average number of patients cared for by a single hospice in a year has nearly tripled.

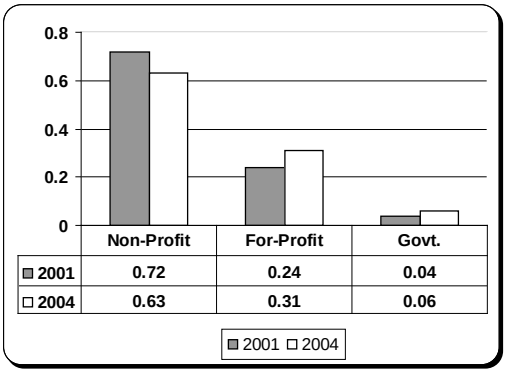
Figure 3: Average Number of Patients per Hospice: 1985 – 2004



(NHPCO November 2005)

The hospice industry has traditionally been comprised of non-profit operations (NPs). The first for-profit hospice was not formed until the mid-1970s. Currently, for-profit hospices (FPs) comprise over 30% of all hospice sites, as Figure 4 on the following page shows.

Figure 4: Trends in Hospice Profit Status (2001 – 2003)



(NHPCO November 2005)

Prior to the institution of the Medicare Hospice Benefit in 1986, there was little financial incentive for FPs to enter the market. The Medicare benefit, along with the dramatic growth trends in patients seeking hospice care, has attracted for-profit players.

Changes in the US healthcare landscape have created significant challenges for the hospice industry, as hospices become an increasingly important component of the healthcare continuum. The primary challenge is in creating awareness and educating all parties that hospice care is available to them and largely paid for by Medicare and Medicaid. Brand awareness has become increasingly important, as consumers sort among the myriad of healthcare providers to make an ever-increasing number of healthcare decisions.

In addition to raising awareness, hospices also face the challenge of rising costs to deliver the hospice services, particularly in the areas of human resources, pharmaceuticals, and

durable medical equipment. Operational efficiency is critical to long-term survival. For certain NPs, this situation is exacerbated by declining trends in revenues from their traditional sources such as personal donations and government grants.

With the underlying objectives of revenue growth and profitability, FPs address these problems with a business approach to operations and marketing savvy that is not easily matched by their nonprofit counterparts.

Their success has further squeezed the NPs, who must either begin to emulate their larger competitors or be forced to close or be acquired. The end result is that the growing demand for hospice care is being serviced increasingly by the for-profits.

The Marketing Strategies of For-Profit Hospices

In order to be certified by Medicare, providers of hospice services are required to offer specific core and non-core services. However, marketers at certain FPs have recognized the value of differentiating their services to appeal to certain types of referrers. Certain national or regional health care providers require a fairly wide breadth of services in order to meet all of the needs of their diverse clientele. Thus, in order to be an attractive partner, FPs are expanding their offerings to include certain forms of acute care and the use of inpatient facilities.

Further, as FPs have become savvy about which diagnoses lead to greater profitability, they have modified their service offerings and directed their recruitment efforts to patients with specific diagnoses. Recently, several of the largest for-profit hospice operators have seen the wisdom of offering inpatient facilities and have identified the establishment of IPUs (inpatient units) as a priority. In tandem with geographic build-out strategies, they hope to compete more effectively for referrals from large healthcare providers.

Having a broad footprint in a particular geography aids large FPs in receiving referrals from similarly broad-based health care providers. National and regional nursing home and assisted living communities often seek the administrative and service consistency benefits resulting from working with a limited number of broad-based hospice service providers. When these partnerships are established, the for-profit hospice relies on hospitals and retirement communities to generate referrals to their company. For example, when a person becomes terminally ill in a hospital or retirement community, a staff member from the organization will recommend that the patient seek hospice care with the hospice provider they are partnered with. These partnerships are a primary method used by FPs to increase admissions. The FPs have increasingly carved out resources in their operational budgets to establish personal selling teams to call on the various referring entities. Compensation plans are geared around numbers of referrals and types of patients obtained. In some cases, the teams specialize by type of client, such as nursing homes and oncology centers.

By growing their operations in footprint and scale, FPs are not only better able to cater to the larger healthcare providers who increasingly control the lion's share of referrals, but they also achieve levels of scale that allow them to maximize the efficiency of their operations, thereby freeing up resources to dedicate to their marketing efforts. For their part, there are cases of NPs engaging in more sophisticated marketing strategies and pursuing strategies related to establishing greater scale. However, this is more the exception than the rule in the realm of nonprofit hospices.

A Macromarketing Perspective

Hunt defines macromarketing as "…the study of (1) marketing systems, (2) the impact and consequences of marketing systems on society, and (3) the impact and consequences of society on marketing systems" (Hunt 1977). Hunt is clear in his indication that the impacts flow in both directions – from society to marketing systems and from marketing systems to society. Thus, the study of the macromarketing effects of phenomena involves the examination of the symbiotic impacts of the market forces and society at large, with the direction of causality sometimes difficult to determine.

For the hospice industry, the federal and state governments have played a large role in shaping the business environments in which providers of hospice services operate. The government largely dictates the activities of the industry through its policies and guidelines, as well as its re-imbursement rates. It is not clear whether the US government intended to entice FPs into the hospice industry in 1986. However, the establishments of the hospice benefit under Medicare and the annual "cost of living" increases have provided a market environment where FPs appear to flourish.

In turn, the impact of the marketing programs by hospice industry players, both FPs and NPs, has been to increase the awareness of hospice services among the national and regional healthcare providers who refer large segments of the hospice patient base, as well as among patients and their families. Hospice services have been positioned as a lower-cost alternative to end-of-life care to healthcare providers, and as a more comfortable and dignified manner of coping with terminal illness to patients and their families. Without these marketing efforts, the levels of awareness and usage of hospice services in the US would likely be far lower than they are today.

Despite the growth in overall hospice use, one might become concerned about what appears to be the increasing lack of viability of the non-profit sector of the industry. The trials and tribulations of the smaller NPs are frequently covered in the popular press (Le Claire 2004) In the current market environment, the inherent advantages of the for-profit hospices includes their superior access to ready capital, their greater scale and geographic footprint, and their emphasis on business management and marketing acumen. Although no industry projections can be found, it would not be surprising to see the FPs continue to expand in number, size and influence, and the NPs recede until FPs comprise more than half of the industry customer share in the near future.

In the long run, the industry may evolve to a situation where the FPs service the needs of the profitable segments of the industry, while NPs are relegated to servicing the needs of the least profitable customers in the industry. Under this bifurcated system, the FPs would service the profitable portion of the industry, while the NPs would be relegated to servicing the least profitable segments of the industry. Some believe that this industry configuration may be most desirable, as it leads to the most effective and appropriate use of society's resources (Dees and Anderson 2003). Others argue that the mission and methods of the NPs and the FPs are sufficiently different to believe that society is not best served by the increasing role of FPs (Woolhandler and Himmelstein 2004a).

For-profits have made incursions into other areas of healthcare, including hospitals and dialysis centers. Some claim that these operations thrive while offering inferior services (Himmelstein and Woolhandler 2004b).

Several analyses of the services provided by FPs relative to NPs have been conducted, with the results being largely inconclusive. Utilizing data from 1997 from California hospices, Lorenz, et al. determined that any differences in services were driven primarily by differences in types of patients served (Lorenz, et al 2002). Lindrooth and Weisbrod (2004) came to a similar conclusion, highlighting the notion that FPs were less likely to admit patients with diagnoses related to shorter lengths of stay (e.g., cancer), and posited that this is done by skimping on services offered for patients with such diagnoses. They also noted that FPs appear to admit patients at earlier stages of their illnesses. Finally, Carlson, et al (2004) found that patients at FPs received a significantly narrower range of services. More specifically, they found that FPs provided significantly fewer non-core services relative to NPs.

In order to better assess both the pros and cons of the for-profit incursion into the traditionally nonprofit hospice industry, we can look to some of the basic frameworks of previous macromarketing investigations. In particular, this article considers dominant social paradigm (DSP) theory and exchange theory.

Dominant Social Paradigm (DSP) Theory

The best place to start in the discussion of the critical differences between FPs and NPs is in examining their fundamental mission and objectives. One useful approach may be to examine the issue from the standpoint of dominant social paradigm (DSP). Fundamental to DSP theory (Pirages and Ehrlich 1974) is the notion that, within any culture, there develops a paradigm (or world orientation) which provides the background against which the operators in that culture size up situations, make decisions, and execute marketing programs. Kilbourne (Kilbourne and Beckmann 2002; Kilbourne et al. 2002) has established three primary dimensions of DSP in Western industrialized societies: economic, political and technological. According to Kilbourne, these main dimensions must be congruent and mutually reinforcing in order for the firm to operate successfully in the larger society (Kilbourne and Beckmann 2002). In examining the impact of DSP on the marketing appeals of non-profit organizations, Marshall and Kilbourne propose that FPs and NPs indeed have DSPs which are markedly different from their FP counterparts, which are reflected in worker values, motivations and desired

organizational outcomes and strategies (Marshall and Kilbourne 2005). The DSP of the NPs is posited to include a greater orientation to social service, participatory management, cooperative rather than social relationships and volunteerism. Himmelstein and Woolhandler put these differences into stronger terms:

"Investor-owned healthcare embodies a new value system that eradicates any vestige of the community roots and Samaritan traditions of hospitals, makes doctors and nurses into instruments of investors, and views patients as commodities." (Himmelstein and Woolhandler 2002)

Marshall and Kilbourne further propose a typology of NPs based upon three broadly defined dimensions: organizational structure, funding sources and mission. Where a particular NP falls into the various cells delineated by these three dimensions impacts the manner in which it markets its services to society. Inasmuch as NPs are comprised of a relatively diverse mix of operators, this implies that the objectives and programs of NPs are diverse as well. In contrast, FPs are considered to be relatively homogenous in their objectives and methods, being focused on profitability, creating shareholder wealth, and marketing programs designed to increase revenues and profitability.

Exchange Theory

Alternative DSPs would, in theory, lead to alternative methods of value creation and exchange. Bagozzi (1975) delineates three types of exchange situations that differ in terms of the relationship enjoyed between the partners in the exchange. *Restricted exchange* involves direct, reciprocal transfers of value between consenting parties. This is represented by typical, for-profit exchanges such as purchasing a toothbrush at the local drug store. *Complex exchange* involves direct, two-way exchanges among actors who then engage in other direct, two way exchanges with other actors. The net effect is a series of direct dyadic exchanges that mutually satisfy all parties. A good example of complex exchange would be the two-way relationships between the toothbrush manufacturer, the drug store retailer, and the consumer. The consumer never has a direct exchange with the manufacturer. Finally, *generalized exchange* involves a series of indirect, univocal, reciprocal transfers among at least three actors. Under this scenario, Actor A provides something of value to Actor B, who in turn provides something of value to Actor C, who, in completing the "loop", provides something of value back to Actor A. In effect, the generalized exchange represents more of a closed system than complex exchange. In generalized exchange, the social actors form a system in which each party gives to another but receives from someone other than to whom he gave. In the real world, these three types of exchange occur together and in various forms. Marshall has confirmed the notion of generalized exchange as a framework for examining society's relationship to public schools (Marshall 1998) and recruiting for the armed services (Marshall and Brown 2003). The hospice industry provides an excellent opportunity to re-examine differences in exchange theory dynamics between nonprofit and for-profit entities.

Areas For Future Exploration

This article provides an introduction to the hospice industry and an overview of its growth and prospects. In particular, it highlights the growth of the nonprofit players, and points out some differences in their marketing approach to the industry relative to their nonprofit counterparts. Further study of the macromarketing impacts of the incursion of for-profits into a traditionally nonprofit industry would include developing a better understanding of the growth dynamics of the industry, as well as further work in applying aspects of dominant social paradigm theory and exchange theory to hospice industry dynamics. More specifically:

Further Examination of Industry Growth and Consolidation Trends
Additional work can be done in quantifying the role that the nonprofits have played in fostering industry growth and in contributing to industry consolidation. Relatedly, more work can be done to better profile the nonprofit hospices, where it is assumed that the population of hospice entities is more diverse, and the ability to compete in the rapidly changing environment is varies markedly.

Social Marketing and Issues of Public Policy
Further examination of the U.S. government's implicit and explicit public policy agenda with respect to the hospice industry can be further explored. Both intended and unintended impacts should be assessed relative to policy intent and goals. One could profile government policy in the hospice care industry relative to other industries where the government has pursued a more active role in "social marketing", such as the "Buckle up" seatbelt campaign or the "Stop smoking" campaign.

DSP Theory and Exchange Theory
This article only introduces the reader to the role that dominant social paradigm theory and exchange theory can play in better understanding hospice industry dynamics in general and marketing practices specifically.

Future work in this area should include the explication of a DSP model for the hospice industry that profiles its development along the three dimensions of economic, political and technological. This would likely lead to some enlightening conclusions in regard to the future course of the industry, as well as provide insight into the marketing practices of both the nonprofit and for-profit players.

In addition, the work of Marshall in the area of investigating generalized exchange in the context of nonprofit industries can be extended to an analysis of the hospice industry. Work in this area would likely yield tremendous insights into the manner in which the incursion for-profit entities upsets the prevailing notion of general exchange and transforms an industry into a model of complex exchange.