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An Analysis of the Marketing Strategy of Florida Nursing Homes.

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ABSTRACT

The purpose of this research was to study how nursing homes are marketed. The method of analysis was to investigate the marketing strategy of a sample of Florida nursing homes. The primary hypothesis was that nursing homes design their marketing mix around the medical needs of their target market.

Nursing homes are primarily a post World War II industry and have evolved as an institutional solution to the needs of the aged. Medical care has lengthened man's life and brought about a need for long-term care of the aged. These aged are financially secure and no longer depend upon their children to provide for their care. Meanwhile, hospitals have become specialists in short-term care, and nursing homes have evolved to provide the long-term care needed by the aged. Thus the market demand for nursing homes comes from persons in need of intensive, hospital-like care, and from those needing only minimal care which is no longer available from the children of the aged.

The analytical portion of this study was based upon a mail survey of ninety-seven Florida nursing home administrators. The objective of the survey was to determine the

target market of each nursing home and the nature of the home's marketing mix. The nursing home market was segmented by the degree of care required by patients, and three degrees of care were identified: intensive, limited, and minimal. The surveyed nursing homes were categorized according to which group of patients the home specialized in. The marketing mixes of these three categories of homes were compared for significant differences in the mixes and for the appropriateness of the mixes to the needs of the target markets of the homes.

The following conclusions were reached with regard to the marketing strategy of the surveyed nursing homes:

1. The target market for nursing homes was defined in terms of the medical needs of patients.

2. The marketing mix of nursing homes was appropriate to the needs of the home's target market.

3. The primary competitive tool of nursing homes was the product mix: that combination of medical care, facilities, and personal services provided for patients.

4. The location of a nursing home was an important competitive tool and was affected primarily by the convenience of the site to physicians and to a hospital.

5. Promotion was considered the least important component of the marketing mix of nursing homes.

6. The pricing of nursing home services was used to a limited extent as a competitive tool.

The conclusions on the relative role of the components of the marketing mix are better understood in light of the current market conditions of the nursing home industry. The demand for nursing homes had grown so rapidly in recent years that the supply had not been able to keep up with demand. A "sellers' market" existed in many market areas. This condition was further stimulated by the growing role of the Federal government in assuming the financial obligation for patient care. For this reason, the major marketing consideration of nursing homes was the product mix, rather than promotion, location, or pricing policies.

This study has shown how nursing homes were marketed. Additional studies are needed on the marketing of services, especially the marketing of medical services. It is believed that this study has provided basic information on how services are marketed and on the specific marketing problems of the nursing home industry.

CHAPTER I

INTRODUCTION TO THE STUDY

The primary emphasis of marketing scholars has been, traditionally, on the marketing of goods rather than services. Examples of this emphasis are found in the early work of marketers on the marketing of agricultural products and in the current popularity of the "marketing management" concept, which is primarily concerned with physical goods. Though services play a secondary role in the study of marketing, they are of major importance to the economy. Service industries account for over forty per cent of the Gross National Product.[1]

With this traditional emphasis on the marketing of physical goods, only limited research on the marketing of services has been conducted. Studies on the role of marketing in particular service industries are needed to further

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[1]William J. Regan and Cornelis Visser, "The Elusive Service Market," William Lazer and Eugene J. Kelley, Managerial Marketing: Perspectives and Viewpoints, revised edition (Homewood, Illinois: Richard D. Irwin, Inc., 1962), pp. 151-158.

the development of marketing as an academic discipline.

This research project has been an investigation into the marketing of nursing home services. The nursing home industry is a rapidly growing and changing service industry that has been the subject of limited study. The role of marketing in nursing homes has been neglected by individuals in the industry and by researchers. This study provides a foundation study of the role of marketing in nursing homes and adds to the total body of knowledge on marketing in service industries.

IMPORTANCE OF THE STUDY

Nursing homes are of growing importance to society. Changing social, economic, demographic, and medical conditions have stimulated the demand for nursing homes. Life expectancy has been increasing in the United States.[2] People are surviving, more and more, to old age when the chronic diseases, such as arthritis, cancer, and heart

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[2]Dr. Morton Leeds, "Geriatric Implications of the Medical Revolution: A Biologic Pandora's Box," Journal of the American Geriatrics Society, Vol. II, No. 5 (May, 1963), pp. 409-418.

disease, have greatest frequency.[3] A growing number of aged are now in need of long-term medical care. Social conditions have changed to the point that children no longer assume the responsibility for care of their aging parents.[4] These changing conditions, along with the growing affluence of the country, have stimulated demand for an institutional solution to the need for long-term care of the aged.

Prior to the development of the modern-day nursing home, the hospital had been the only source for long-term care of the aged. Hospitals have grown rapidly in the United States, especially in terms of the number of services and facilities they offer their patients. As their range of services have grown, their costs have increased proportionately.[5] Nursing homes have developed as an alternative to

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[3]Arnold M. Rose, "Aging and Social Change: Implications and Challenges," University of Florida Institute of Gerontology, Social Change and Aging in the Twentieth Century, Vol. 13 (Gainesville, Florida: University of Florida Press, 1964), p. 2.

[4]Leonard Broom and Philip Selznick, Sociology: A Text with Adapted Readings (Evanston, Illinois: Row, Peterson and Company, 1956), p.39.

[5]The American Hospital Association estimated average per diem costs in a hospital in 1965 at $57.93 and forecast costs to rise to $70.00 per day by 1970. Refer to "Hospitals Try to Cure a High-cost Syndrome," Business Week (July 15, 1967), pp. 128-132.

hospital care, at a cost substantially below hospital costs.[6]

Nursing homes are primarily a post-World War II phenomenon and now, with Medicare, the nursing home industry is experiencing its period of most rapid growth. The number of nursing home beds in the United States doubled during the period from 1961 to 1966, and today there are over 13,000 nursing homes doing almost a two billion dollar business annually.[7]

Although the industry has experienced rapid growth, research on the industry has been limited. Most published material relating to nursing homes has been concentrated in medical and other technical areas. Studies on the marketing and other business aspects are practically non-existent. The influx of large amounts of capital into the nursing home field, by large national corporations, is stimulating demand for studies on the marketing of nursing homes.

Marketing studies of nursing homes are needed because of the industry's growth and its changing role in the economy and in its importance to society. Marketing is important in

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[6]A 1967 nationwide survey estimates the cost per patient day in a nursing home varies from $9.42 to $12.16. Refer to "Planning Guide," Professional Nursing Home, Vol. 17, No. 12 (December, 1967), p. 43.

[7]"Nursing Homes Offer an Investment Lure," Business Week (July 23, 1966), pp. 113-114.

a nursing home's total competitive effort, and research in this area is needed by the industry to assure its continued growth and development.

STATEMENT OF THE PROBLEM AND MAJOR HYPOTHESES

This study was undertaken to analyze the role of marketing in nursing homes. Marketing was one aspect of the nursing home's total competitive effort that has received little attention from both researchers and practitioners. This investigation was centered on the problem that the role of marketing in nursing homes is little understood in relationship to the total competitive effort of the firm.

This problem was analyzed so as to test the validity of certain hypotheses. The primary hypothesis to which this study was addressed is:

> The nursing home market can be segmented by the medical needs of patients, and a marketing mix can be effectively designed around these market segments.

The primary objective of this study was the investigation of the above-stated hypothesis. The following secondary hypotheses were used to guide this study.

> Segmenting the nursing home market by the medical needs of patients is a most effective method of defining a firm's target market.

Price is generally not used as an effective competitive marketing tool in nursing homes.

Location decisions are used to limited extent in establishing a differential advantage.

Promotion policies do not occupy a critical role in the firm's marketing strategy.

The primary method of establishing a differential advantage is by the nature of the "product" offered.

DEFINITIONS AND TERMINOLOGY

To facilitate effective communication, selected terms important to this thesis are defined in the following paragraphs.

Nursing home: Since this investigation was restricted to nursing homes in Florida, the definition of nursing homes used in this study was that which is used by the Florida State Board of Health. The Board of Health is the licensing agency for all Florida nursing homes. It defines a nursing home as "a care facility providing nursing service . . . in addition to custodial service for persons under medical supervision who do not require hospitalization."[8]

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[8]Florida State Board of Health, Rules and Regulations for Health Facilities, Jacksonville, Florida, 1968, p. 203.

The degree and extent of the services and care available at a nursing home varies widely. At one extreme are homes just meeting the minimum standards established by the Board of Health regarding facilities, staffing, and care provided. An example of this type of facility is a nursing home in a converted residence, with the minimum staff, and offering no special services such as occupational therapy or entertainment.

At the other extreme is the large, modern home, especially designed as a nursing home. The characteristic distinguishing this type of home from a hospital is frequently only the absence of special departments, such as maternity or surgery. The large home may be in a multi-million dollar physical plant with employees numbering in excess of one hundred. This institution may have a full-time social director, swimming pool, beauty shop, and a wide range of other services.

Aged: The term aged refers to the generally accepted definition of the aged as being persons aged sixty-five and over. Age sixty-five is the arbitrarily selected age for retirement set by the Social Security Act and many business retirement programs. The process of aging is a far more complex phenomenon than is indicated by reaching age sixty-five. It involves the slow degeneration of the physical and mental

processes of an individual, and its timing varies substantially among individuals. The term aged, as used in this study, refers to all persons aged sixty-five and over, regardless of the stage of the aging process they are in.

Influential: The decision on the selection of a nursing home for an individual is usually not made by the patient alone. A relative or other individual frequently assists in the selection of a nursing home. A second party often affects the decision on a nursing home, and in this study this second party is referred to as an influential.

The most common influential is the family physician. The doctor is probably the one to suggest initially the need for a nursing home, and very likely he expresses a preference for a select few homes. Other examples of influentials are welfare workers, ministers, trust officers of banks, and lawyers. Influentials are important in the determination of the marketing policies that a nursing home pursues.

Administrator: The top administrative official of a nursing home is referred to as the administrator. He or she may be a full-time professional manager but often is a nurse who assumes duties other than management.

Patient: The resident in a nursing home is referred to as a patient. This is a commonly accepted term but does not necessarily mean that a person is physically or mentally ill.

Marketing strategy: Success in the marketplace necessitates a marketer's determining the proper strategy to follow in attaining the desired goals. This marketing strategy consists of two steps. First, a target market is defined, and then an appropriate marketing mix is selected.[9]

The target market concept is based on the idea that a firm cannot satisfy all the people all the time, but it can satisfy a select group of people most of the time. The target market selected must be identifiable and homogeneous in character, and it must be possible to delineate it by either demographic and/or socio-psychological characteristics.

For a nursing home, a target market can be segmented according to several criteria. Possible segmentation approaches are the source of payment for services rendered (public or private), sex, religion, duration status (short-term or long-term patients), and medical needs of patients (intensive or minimal). The target market that a nursing home selects is dependent on the resources and objectives of the firm and the existing market conditions.

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[9]Alfred R. Oxenfeldt, "The Formulation of a Market Strategy," William Lazer and Eugene J. Kelley, Managerial Marketing: Perspectives and Viewpoints, third edition (Homewood, Illinois: Richard D. Irwin, Inc., 1967), pp. 98-108.

After selection of the particular target group of customers, a firm selects an optimum combination of marketing tools to best achieve the firm's basic objectives. The elements selected are designed to yield the most effective combination of marketing factors available within the given restraints and objectives.

The marketing elements can be broken down to product, price, location, and promotion. All four of these elements were analyzed with respect to a nursing home's marketing strategy.

Price policies are declining in importance to the nursing home's marketing strategy because of the growing importance of Medicare and other insurance programs applicable to nursing home care. With an insurance program paying the bill, patients tend to be less price-conscious.

Location policies of a nursing home are influenced by the people to whom the home seeks to make its primary appeal. A nursing home may appeal to patients, influentials, or the hospital.

Promotion in nursing homes includes not only that which is directed to the general public, but also that which is directed to special segments. Examples of this are advertising in medical journals in order to appeal to physicians and advertising in a Grandmother's club newsletter to appeal

directly to customers.

The product policies that a nursing home pursues consist of all the services and facilities a home provides. This would include such factors as the construction and architecture of the building, the quality and quantity of nursing home care provided, and the special services provided, such as a beauty shop or occupational therapy.

The marketing strategy, to be effective, needs to be re-evaluated regularly. Changing market conditions may affect the marketing policies a firm follows.

Size of a nursing home: The size of a nursing home is determined by the number of beds a facility is licensed for by the state. Federal law requires that states license nursing homes. In Florida the State Board of Health is the regulating agency for nursing homes and as such, sets the minimum standards for nursing homes. These regulations concern such matters as the number and type of employees and the number and type of sanitation facilities needed for various sizes of nursing homes. For a nursing home to be licensed for a specific capacity, it must meet the minimum standards established by the State.

Ownership: In this study two classes of ownership of a nursing home were used; profit-making and non-profit homes. Non-profit homes include government, church, fraternal, and other voluntary homes.

SCOPE AND LIMITATIONS OF THE STUDY

This research was a study into the marketing of an industry that has developed primarily since World War II. The scope of the research was of necessity limited to only certain aspects of the marketing policies of nursing homes.

The first section of this thesis is a study of the market for nursing homes and of the evolution of nursing homes. The main part of the research concerns the marketing strategy of nursing homes. The role of market segmentation and of product, price, location, and promotion policies were studied to determine their role in the nursing home's marketing effort.

A major restriction was the limited amount of secondary materials available. Published information on nursing homes is primarily on medical and other technical aspects. Marketing receives only limited attention in nursing home journals. The main source of information for this project was primary research on nursing homes in Florida.

The primary research used in this study was based on a mail questionnaire of Florida nursing home administrators. Many problems are inherent in a mail questionnaire, and an

attempt was made to minimize these potential problems.[10]

For questions seeking specific numerical values, the answers were not always readily available to the respondent. Estimates were called for, thus creating the possibility of bias in the response. An attempt was made to minimize this bias by grouping the data into usable ranges, rather than using specific values.

Another bias existing in the responses was the desire of respondents to project as good an image as possible and give the most desirable answer. The questionnaire was designed to minimize this problem, but a certain amount of bias in responses did exist. It was assumed that this bias was not sufficient to distort the results of the study.

The number of returns provided another restriction on the study. The questionnaire was mailed to the universe, which was defined as all Florida nursing homes. Since less than one hundred per cent of the mail questionnaires was returned, the results of the survey may not necessarily be representative. The sample of nursing homes returning the

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[10]Refer to Harper W. Boyd, Jr. and Ralph Westfall, Marketing Research: Text and Cases, revised edition (Homewood, Illinois: Richard D. Irwin, Inc., 1964).

questionnaire is not necessarily identical to nursing homes not returning the questionnaire.

Further limitations must be recognized because of the use of a mail questionnaire. The questionnaire was designed to minimize these problems, but there was no feasible approach to evaluate the bias and inaccuracy of responses. The limitations incurred in the study do not restrict the usefulness of the study. With the given resources for the project, certain limitations were unavoidable.

METHODOLOGY OF THE RESEARCH

The methodology followed in this investigation consisted of the collection of the primary data and analysis of this data. This section describes both aspects of the methodology.

COLLECTION OF THE PRIMARY DATA

The data used in this study were collected in a survey specially designed and conducted for this thesis. The objective for which the data were collected was to analyze the marketing strategy of Florida nursing homes. Description of the survey procedures used in this study are covered in this section.

Preparations for the Survey

This study was limited to nursing homes in Florida. The State of Florida was assumed to have a representative sample since Florida has a large proportion of aged and has a large number of nursing homes of diverse types of operation.

A mail questionnaire was used because of the limitation of time, money, and geographical separation of nursing homes. A copy of the questionnaire used is in Appendix A. The mailing list included all homes where the primary business was the operation of a nursing home. Retirement homes which have an adjoining nursing home as a secondary activity, primarily to serve the retirement home residents, were not included on the mailing list.

The list of nursing homes used in the survey was obtained from three separate but over-lapping lists. The primary list was the listing of all nursing homes and related facilities licensed under Chapter 400 of the Florida Statutes. This listing was obtained from the Florida State Board of Health and was current as of December 31, 1967. It provided a total of 262 usable institutions.

The State Board of Health list included only the name and address of the nursing homes. The membership list of the Florida Nursing Home Association was used to obtain the names of the administrators of 165 nursing homes. This listing was

current as of February 1, 1968. By addressing the questionnaires to specific individuals, a higher response rate was anticipated.

A third listing of nursing homes was cross-checked with the Health Department list to update the mailing list. The list of Florida nursing homes approved for Medicare was obtained, and this list was current as of June, 1968. Twenty additional nursing homes were added to the Health Department list. A total of 282 nursing homes were on the final mailing list. This was defined as the universe of the study.

The questionnaire used in the survey, included in Appendix A, employed a combination of types of questions, most of which only required a check mark. Some numerical values were called for, but only an intelligent guess was requested.

The questionnaire was pre-tested with selected Florida and Louisiana nursing home administrators. A total of six administrators and directors of nurses were personally interviewed with respect to the questionnaire. After suggested revisions, the final draft of the questionnaire was three legal pages in length.

Collecting the Data

The questionnaire was mailed during August, 1968. Special effort was made to obtain a maximum number of returns. The questionnaire did not ask for the name of the administrator or the name of the nursing home. A summary of the study was offered for those interested, and a post card was included with the questionnaire in order to make such a request without placing identification on the questionnaire. The name of the home or administrator was not important to the study.

In August, 1968 a personal request was made at the Florida Nursing Home Association convention for its members to complete the questionnaire. In addition to the personal request, all Association members were sent a special cover letter. A personal note was included in fifty-seven mailings from Mr. Don Miller, Sr., of Suncoast Manor Nursing Home in Bradenton, Florida. To the remaining 108 members of the Association, a letter was enclosed from Mr. David Mosher. Mr. Mosher is Regional Vice-President for the Southeastern Region of the American Nursing Home Association. A copy of Mr. Mosher's letter is included in Appendix B.

In addition to the questionnaire, the post card, and the special cover letters, a general cover letter and a postage paid return envelope were included with all mailings.

A copy of the general cover letter is in Appendix C.

Response to the Questionnaire

A total of 102 questionnaires were returned. Two questionnaires were returned with notes explaining that the home had gone out of business. Two additional questionnaires were returned because the homes had not yet opened for business. A fifth questionnaire was not used because it was received after the cut-off date, which was October 1, 1968. Of the ninety-seven usable returns, some questionnaires were not completely filled out. For the specific questions not completed, less than ninety-seven homes were used in the analysis. The 102 returns represented a 36 per cent return.

The sample of ninety-seven nursing homes used in this study was fairly representative of all Florida nursing homes with respect to ownership, size, and geographical dispersion, although minor biases did exist. Comparison of characteristics of the homes in the sample with statewide statistics supports this conclusion.[11] Classifying nursing homes as

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[11]The total number of nursing homes and nursing home beds in Florida was obtained from the Florida State Board of Health, Florida State Board of Health, Annual Report, 1967, Jacksonville, Florida, 1968, p. 111.

either proprietary or non-profit institutions, 88 per cent of the sample was proprietary, whereas only 83 per cent of all Florida homes were classified as proprietary homes. A slight bias in the sample in favor of proprietary nursing homes existed.

With respect to the size of nursing homes, there was a slight bias in the sample in favor of medium sized homes and away from small homes. For small homes, 44 per cent of all Florida homes had fifty or less beds, whereas only 32 per cent of the homes in the sample had fifty or less beds. For medium sized homes of between fifty and one hundred beds, 48 per cent of the sample was in this size category, but only 36 per cent of all Florida homes were in this medium sized category. Twenty per cent of all Florida homes and twenty per cent of the sample of homes were larger than one hundred beds.

The distribution of homes in the sample geographically was fairly representative of all Florida nursing homes. Sixty-three per cent of the counties in Florida with nursing homes were represented in the sample. There was little bias in the sample according to the size of population of the county in which the nursing home was located. The percentage of homes in the sample from small, medium, and large counties corresponds closely with the distribution of all 277 Florida nursing homes.

Based on the above analysis of the representativeness of the sample by ownership, size, and geographical dispersion of the homes, the sample was fairly representative of Florida nursing homes. No major discrepancies existed between characteristics of the sample and of all Florida nursing homes with respect to ownership, size, and geographical dispersion. Other types of biases may exist in the sample, but the assumption used in this study was that these biases did not materially affect the conclusions of this dissertation.

PLAN OF ANALYSIS

The plan of analysis used in this investigation consisted of three steps. First, an analysis of market supply and demand conditions in the aged care industry was conducted, based primarily upon secondary sources of information. Second, market segmentation of the nursing home market was analyzed in order to determine the target market of the surveyed homes. Third, the marketing mix of the surveyed nursing homes was examined with respect to the target market of the homes.

Analysis of Market Conditions in the Aged Care Industry

The objective of this section of the analysis was to determine what were the supply and demand conditions of

nursing homes in Florida. The number of nursing homes and nursing home beds was analyzed for the thirty-eight counties in Florida with nursing homes. Correlation analysis was conducted between selected county statistics and the nursing home facilities in the same counties. The objective was to test for significant relationships that might affect the supply of nursing homes in a particular market area.

Three approaches were used to project the need for nursing homes by county in Florida. These approaches were related to the proportion of population aged sixty-five and over in each county. The objective was to combine the three approaches to obtain one "best" estimate of nursing home needs in a county. These need statistics were then compared to the supply statistics, and the net supply and demand for nursing homes in Florida counties was established.

Analysis of Market Segmentation in the Florida Nursing Home Market

The objective of this portion of the analysis was two-fold. First, the most effective method of segmenting the nursing home market in order to define a target market was determined. The second objective was to determine whether nursing homes actually do define their target market on this basis. The analysis was based upon characteristics of the

patients in the surveyed homes. These characteristics of the patients were used to define the target market of the homes. The surveyed homes were then categorized according to the home's target market, and the categories of homes were compared for significant differences.

Analysis of the Marketing Mix of Florida Nursing Homes

After the surveyed nursing homes were categorized according to their target group of customers, the marketing mix of these categories of nursing homes was analyzed. Based on the assumption that different target markets need to be appealed to by different marketing mixes, the objective was to test for significant differences in the marketing mixes of the various categories of homes. The marketing mix was analyzed with respect to product, location, pricing, and promotion policies of the homes. This analysis was intended to test the hypotheses concerning whether nursing homes actually do follow an effective marketing strategy such that the marketing mix is consistent with the needs of the target market.

PREVIEW OF THE RESEARCH

Chapter II provides the background necessary for an analysis of the marketing strategy of nursing homes. Forces that have affected the evolution of nursing homes were examined in order to provide insight into why nursing homes exist today.

Chapter III analyzes market conditions in the aged care industry. In this chapter the total competitive environment of nursing homes was examined, and the supply and demand conditions of nursing homes analyzed.

Chapter IV analyzes market segmentation of the Florida nursing home market. The most effective method of dividing the nursing home market as a basis of selecting a target market was determined. The surveyed nursing homes were then categorized according to the home's target market. These categories of homes were compared for significant differences.

Chapter V analyzes the marketing mix of Florida nursing homes. The marketing mix of the surveyed homes was analyzed with respect to the needs of the nursing home's target market.

CHAPTER II

EVOLUTION OF NURSING HOMES

As medical institutions specializing in the care of the aged, nursing homes are a relatively new phenomenon. The nursing home of today began to emerge in its present form only after World War II.

The nursing home has evolved under the pressures of various forces. This chapter looks at these forces in order to provide a perspective from which to view the nursing home industry today and its potential future. Five forces are discussed in this chapter: demographic, governmental, economic, medical and social.

Prior to discussion of these forces, a section is included at the beginning of the chapter to provide the background of the evolution of nursing homes. Historical antecedents of nursing homes are traced starting with the European ancestor that was transferred to the United States.

This chapter provides an essential background in order to study nursing home marketing practices. An understanding of the forces responsible for the existence of the nursing home industry of today provides insight as to how the

industry has changed with the changing needs of society. This chapter gives an analysis of the changing consumer needs that have affected the development of the nursing home industry.

HISTORICAL DEVELOPMENT OF NURSING HOMES

The antecedents of the modern day nursing home can be traced back to the sixth century B. C. when institutions existed that specialized in the care of the aged.[1] In later years, during the Middle Ages, the Catholic Church assumed this responsibility, but as the power and importance of the church declined, the state assumed the responsibility for the care of the aged.[2]

ENGLISH ANTECEDENTS OF NURSING HOMES

In England, the state's concern and involvement in public relief for the aged was first provided for in 1535, but the Poor Law of 1601 was the foundation for public

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[1]Samuel Levey and Roger Amida, "The Evolution of Extended Care Facilities," Nursing Homes, Vol. 16, No. 8, (August, 1967), p. 14.

[2]Edwin R. A. Seligman, Encyclopaedia of the Social Sciences, Vol. XI (New York: The Macmillan Company, 1937), p. 8.

relief in England and the United States.[3] This law authorized the levy of a tax to support the poor and classified the type of attention needed for various classes of dependents.

The almshouse, known as the workhouse in England, was authorized in 1601 to be built as "convenient dwellings" for the aged, old, and feeble.[4] The first almshouse was constructed in Bristol and succeeded in decreasing vagrancy and pauperism.[5] The success of the first almshouse stimulated development of others, and further legislation related to them was enacted. The philosophy followed in the workhouse was that the position and condition of residents must be "less desirable than that of the poorest self-supporting laborer."[6] This concept led to an inferior approach to care of the aged and was denounced in England.[7] The primary problem was the general mixing of various types of people.[8] The

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[3]Alexander Johnson, The Almshouse (New York: Charities Publication, 1931), pp. 149-151.

[4]Edwin R. A. Seligman, Encyclopaedia of the Social Sciences, Vol. II (New York: The Macmillan Company, 1937). p. 8.

[5]Ibid.

[6]Johnson, op. cit., p. 156.

[7]Seligman, Vol. II, op. cit., p. 8.

[8]Johnson, op. cit., pp. 141-148.

aged, orphans, the mentally ill, alcoholics, drug addicts, and the sick were all housed together.

EARLY AMERICAN PREDECESSORS OF NURSING HOMES

The United States copied English laws and practices relevant to the care of the aged. The problems inherent in the English system were inherited by the American system. Early in the nineteenth century, the public disgust for almshouses brought about separation of the various classes of the poor.[9] The gradual establishment of institutions specializing in care for groups other than the aged transformed the almshouses into homes for the aged. Persons over sixty constituted one-third of the residents of almshouses in 1880, and by 1932 two-thirds of the residents were over sixty.[10]

In the United States, as in England, the almshouses were under the control of local government. They were established in some instances only because the counties were required by law to provide them.[11] The administration of the almshouses was generally of low quality and was controlled by

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[9]Edwin R. A. Seligman, Encyclopaedia of the Social Sciences, Vol. XIII (New York: The Macmillan Company, 1937), p. 91.

[10]Edwin R. A. Seligman, Encyclopaedia of the Social Sciences, Vol. II (New York: The Macmillan Company, 1937), p. 458.

[11]Minnesota Department of Health, Homes for the Aged and Chronically Ill Persons of Minnesota, Minneapolis, Minnesota, 1959, p. 3.

local political organizations.[12] The objective of the county was to operate on as small a budget as possible, and the workhouse often used its residents to operate a farm and do other tasks with the objective of minimizing costs to the county.

The almshouses provided an unsatisfactory solution to the care of the aged.[13] The administration was generally inept, the staff was limited in number and usually untrained, and the buildings were not properly designed for their functions.[14] The following is an example of improper treatment of residents in almshouses.

> I found one superintendent who declared that he found the horsewhip to be the most efficient means of quieting insane inmates. I found an insane woman who had been kept strapped to a bed for over six years. An insane man was found chained to a stump in a poorhouse yard.[15]

Although the conditions of almshouses were deplorable, their rapid growth continued. As Exhibits 2.1 and 2.2 show,

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[12]Joseph T. Drake, The Aged in American Society (New York: The Ronald Press Company, 1958), pp. 344-345.

[13]Refer to Johnson, op. cit., pp. 141-148 and 236-238.

[14]Drake, op. cit., pp. 344-345.

[15]Johnson, op. cit., p. 236.

the number of residents of institutions for the aged grew in absolute numbers, but did not change much relatively.

EXHIBIT 2.1

ESTIMATED NUMBER OF PERSONS AGE SIXTY-FIVE AND OVER IN INSTITUTIONS OF SPECIFIED TYPE, 1900-1950

	Persons Aged Sixty-Five and Over in Institutions				
	Total	In Institutions Primarily For Aged			Mental Hospital
		Total	Public	Private	
		(In Thousands)			
1950	385	217	60	157	141
1940	222	118	58	60	88
1930	188	132	80	52	56
1920	133	102	71	31	31
1910	109	87	62	25	22
1900	78	65	47	18	13

Source: Jacob Fisher, "Trends in Institutional Care of the Aged," Social Security Bulletin, Vol. 16, No. 10 (October, 1953), p. 9.

EXHIBIT 2.2

ESTIMATED PER CENT OF PERSONS AGED SIXTY-FIVE AND OVER IN INSTITUTIONS OF SPECIFIED TYPE, 1900-1950

	Per Cent of Total Population Aged Sixty-Five and Over In Institutions Primarily for the Aged				
	Total	Total	Public	Private	Mental Hospitals
1950	3.1	1.8	0.5	1.3	1.1
1940	2.5	1.3	0.6	0.7	1.0
1930	2.8	2.0	1.2	0.8	0.8
1920	2.7	2.1	1.4	0.6	0.6
1910	2.8	2.2	1.6	0.6	0.6
1900	2.5	2.1	1.5	0.6	0.4

Source: Jacob Fisher, "Trends in Institutional Care of the Aged," Social Security Bulletin, Vol. 16, No. 10, (October, 1953), p. 9.

The almshouse was primarily a public institution providing a minimum amount of care for its residents. The amount of medical care provided distinguishes the almshouse from the nursing home. In a nursing home, a resident is provided a wide range of services, including medical care.

EMERGENCE OF MODERN-DAY NURSING HOME

The needs of society were in a state of transition at the beginning of the twentieth century, and the almshouse

needed to change with the changing conditions of the time. The almshouse, however, did not satisfactorily meet the needs of society and was becoming very unpopular. Pressures developed in the 1930's, culminating in the Federal Government's passing legislation that brought about the rapid decline in the number of almshouses in the United States. As Exhibit 2.1 shows, from 1930 to 1940, the aged residents in public institutions decreased 11 per cent while the population aged sixty-five and over increased 36 per cent during the same decade.

As the aged left the almshouses, boarding houses were organized to care for the aged. These boarding houses, which were usually converted residences, originally provided only room and board, not medical care. As the residents of the boarding houses grew older, they needed more care. The homes began to offer nursing care, and the boarding houses evolved into nursing homes.

The residents in these private institutions increased substantially during the 1940's. As shown in Exhibit 2.1, there was a 160 per cent increase in persons aged sixty-five and over in private institutions from 1940 to 1950. Both relatively and absolutely, there was a major increase in the residents of private institutions, whereas public homes decreased in relative importance.

The evolution of the almshouse into the nursing home took place primarily in the twentieth century. Various forces interacted to bring about a need for medical care facilities for the aged. The following sections of this chapter examine those forces affecting the evolution of nursing homes.

DEMOGRAPHIC CHANGES IN THE UNITED STATES

The population age sixty-five and over has been growing at a faster pace than the total population of the United States. Since 1950, the total population has increased 32 per cent, while the age sixty-five and over population segment has increased 55 per cent.[16] The aged have been growing in both absolute and relative importance in the United States. Exhibit 2.3 compares the growth in total population with the population age sixty-five and over in the United States from 1900 to 1968.

The growth of the aged in relative terms may be leveling off. As Exhibit 2.3 shows, in the percentage growth over the previous decade, the population age sixty-five and over did not increase as much relatively during the past eight years as it had in previous decades. Using

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[16]Refer to Exhibit 2.1.

EXHIBIT 2.3

DISTRIBUTION AND CHANGE IN THE TOTAL POPULATION AND POPULATION AGED SIXTY-FIVE AND OVER FOR THE YEARS 1900 TO 1968

Year	Total Population		Percentage Increase over Previous Decade	Population 65 & over		Percentage Increase over Previous Decade	Aged as % of Total	Med Age
	No. (000,000)	% increase over 1900		No. (000,000)	% increase over 1900			
1900	76.2	---		3.1	---		4.1	22.9
1910	92.2	21		4.0	28		4.3	24.1
1920	106.0	39	15	4.9	60	22	4.6	25.3
1930	123.2	62	16	6.6	115	35	5.4	26.4
1940	132.2	73	7	9.0	193	36	6.8	29.0
1950	151.3	99	14	12.3	296	37	8.1	30.2
1960	179.3	136	18	16.6	438	35	9.3	29.5
1968	201.2	164	12	19.1	516	15	9.0	27.7

Source: Data for 1900-1960 from U. S. Department of Commerce, Bureau of the Census, U. S. Census of Population: 1960, Vol. I, "Characteristics of the Population," Part I, U. S. Summary, pp. 1-153, Table 47.

Data for 1968 from U. S. Department of Commerce, Bureau of the Census, Current Population Reports, Population Estimates, Series, p. 25, No. 400, August 13, 1968, p. 2, Table 2.

the 1970 population estimates of Exhibit 2.3, the percentage increase in the group age sixty-five and over is 24 per cent. This is substantially below the average percentage increase of the previous decades. The estimated growth from 1970 to 1980, according to Exhibit 2.4, of those age sixty-five and over is only 12 per cent.

EXHIBIT 2.4

A COMPARISON OF TOTAL POPULATION AND POPULATION AGED SIXTY-FIVE AND OVER: 1965-1985

Year	Population* (000,000)	Population 65 and over (000,000)	Aged as % of Total
1965	194.6	18.2	9.4
1970	208.9	20.6	9.9
1975	227.5	21.2	9.3
1980	249.4	23.1	9.2
1985	273.3	24.1	8.9

*Total population estimates based upon assumption that 1962-65 level of fertility will continue.

Source: U. S. Department of Commerce, Bureau of the Census Current Population Reports: Population Estimates; Series p. 25, No. 329, March 10, 1966.

Thus, the aged population in the United States has increased very rapidly in the past sixty years. The growth rate of the aged is declining and their proportion, relative

to the total population, is leveling off.

Another aspect of demographic changes is the changing living conditions of the population. The population has changed from an agrarian to an urban oriented society. The industrial revolution necessitated a large, mobile, and concentrated labor force. Industrial development brought about a transition in this country from a predominantly rural agricultural nation to an urban industrial nation.

This movement to the urban centers has been in both absolute and relative terms, with approximately 70 per cent of the aged currently living in urban areas.[17] Of these twelve million, slightly more than two-thirds are located in the central city and the rest in the suburbs.[18] This concentration of the aged enhances the appeal of this population segment to marketers.

This shift from rural areas to urban centers was primarily a movement of younger people seeking a "better life." As these younger people moved to the cities, the older members of the family were left on the farm alone.

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[17]U. S. Senate, Special Committee on Aging, New Population Facts on Older Americans, 1960, Eighty-eighth Congress, Second Session, May, 1964.

[18]Fabian Linden, "The Sixty-fives and Over - I," The Conference Board Business Record, Vol, XIV, No. 11, (November, 1962), pp. 34-35.

The parents could no longer have a gradual retirement by turning the farm over to their children. When older persons moved to the cities, they faced retirement in a new and different environment. No longer could they participate in a gradual retirement on the farm.

This movement from the country to the cities is one force creating a need for institutional solutions to problems concerning the aged. The concentration of the aged increased the feasibility of institutions specializing in care of the aged.

CHANGES IN THE ROLE OF THE FEDERAL GOVERNMENT IN THE NURSING HOME INDUSTRY

Three pieces of Federal legislation have had a major effect on the development of nursing homes. They are the Social Security Act of 1935, the 1950 Amendments to the Social Security Act, and the Medicare Act of 1965. This section provides an analysis of the effect of these three acts on the evolution of nursing homes.

THE SOCIAL SECURITY ACT OF 1935

Prior to the 1930's, the Federal Government took a minimal role in the life of aged citizens. The care of the aged was a burden of state and local governments. Beginning

in the 1930's, the Federal Government adopted a new philosophy of assuming responsibility for the welfare of its citizens. One result of this philosophy was the passage of the Social Security Act in 1935. The major provision of the Act was for a limited retirement income for persons past the age of sixty-five.

The effect of the Act on the development of nursing homes was greater than just changing the economic status of the aged. The growing public opinion against the wretched conditions in almshouses prompted Congress to attempt to do away with them.[19] Title I of the Act prohibited payments to residents of public institutions, primarily almshouses and similar institutions.

Title I was included in the Act not only in an effort to get rid of almshouses, but also to keep the states and local governments from unloading their responsibilities onto the Social Security Program.[20] The results of this section in the Act were not exactly what Congress anticipated. The

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[19]Jacob Fisher, "Trends in Institutional Care of the Aged," Social Security Bulletin, Vol. 16, No. 10 (October, 1953), p. 9.

[20]Ruth Brecher and Edward Brecher, "Nursing Homes," Clyde Vedder and Annette Lefhowitz, editors, Problems of the Aged (Springfield, Illinois: Charles C. Thomas, 1965), p. 87.

Social Security payments were inadequate to support the aged outside institutions. Those accepting Social Security often only changed from "the public slums of the poorhouse to the private slums of rooming houses."[21]

As shown in Exhibit 2.1, the total residents in public institutions decreased from 1930 to 1940. The decrease varied among the states. A survey, two years following the start of Social Security, reported that sixteen states had a substantial reduction in the almshouse population, sixteen states reported very little effect, and seven reported an increase in the number of residents.[22]

The reason for the mixed reaction of almshouses to Title I was that Congress had not considered the composition of the residents. Many of the residents were "physically, mentally, and tempermentally" unfitted to move out of the poorhouses.[23] By remaining at the almshouse, the aged had the security of room, board, and an orderly life.

The prohibiting of payment to residents of public institutions stimulated the growth of private institutions.

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[21]Drake, op. cit., p. 346.

[22]U. S. Bureau of Labor Statistics, "Effect of Social Security Program on Almshouses," Monthly Labor Review, Vol. 47, No. 3, September, 1938, pp. 518-524.

[23]Minnesota Department of Health, op. cit., p. 9.

From 1940 to 1950, there was a 900 per cent increase in the number of private homes caring for the aged.[24]

The demand for institutional care was great in the 1940's, but the supply available was unsatisfactory.[25] Inflation caused institutional costs to rise faster than Social Security payments increased, and the boarding house was in difficulty. As the residents grew older, they needed more nursing care, but the boarding houses could not afford to give more. In addition, World War II restricted construction of new homes and limited the labor force available to care for the aged. The Social Security Act intended to do away with the problems of almshouses by legislation, but it did not provide the facilities or services to solve the problems. The Act just substituted the problems of the private institution for the problems of the public institution. The 1950 amendments to the Social Security Act attempted to rectify the problems created by the 1936 Act.

THE 1950 AMENDMENTS TO THE SOCIAL SECURITY ACT

The 1950 Amendments to the Social Security Act had two provisions that affected the development of nursing homes.

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[24]Fisher, op. cit., p. 12.

[25]Brecher, op. cit., p. 86.

First, the prohibiting of payments to residents of public institutions was cancelled, and second, states were required to establish a standard-setting or licensing agency.

Congress was unsuccessful in eliminating the problems of institutional care of the aged by prohibiting Social Security payments to residents of public institutions. By retarding the development of public institutions, Congress put the burden of care of the aged on private enterprise. Apparently, this was no major improvement over the public institution.

The growing demand for institutional care of the aged and the growing number of aged on welfare prompted Congress to drop the prohibition of Social Security payments to residents of public institutions. This provision stimulated the building and expansion of nursing homes by states and counties.[26]

The abuses of institutions caring for the aged had received enough public attention that Congress attempted to upgrade the quality of nursing home care.[27] The 1953 Social

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[26]Ibid., p. 87.

[27]Drake, op. cit., p. 350.

Security Amendments had a provision that states must establish and maintain a code of minimum standards for nursing homes. This provision became operative on July 1, 1953, and since that time there has been a gradual improvement in the quality of nursing homes in the United States.

Congress also attempted to improve the quality of nursing homes in the 1950's by stimulating the construction of new homes. In 1954, Congress, through the Hill-Burton program, authorized funds for the construction of public and voluntary non-profit nursing homes. By mid-1961, a total of 16,414 skilled nursing home beds had been approved for construction.[28] In the 1950's, the government stimulated the development of proprietary nursing homes by authorizing the Small Business Administration to guarantee loans to nursing homes. By 1961, $4.51 million had been approved for nursing homes.[29]

MEDICARE

The third major piece of Federal legislation relevant to the nursing home industry was "Medicare." Medicare was signed into law in 1965, but its effects on the nursing home

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[28]Jack C. Haldeman, "Long-term Care: A Backdrop of Facts," Hospitals, Vol. 36 (January 16, 1962).

[29]Ibid.

industry began when President Kennedy started serious consideration of Medicare in the early 1960's. This legislation is having a dramatic effect on all aspects of nursing homes.[30] The major effect on the development of nursing homes has been the large amount of investment that is flowing into the industry.[31]

Approximately half of the 600,000 nursing home beds in the United States were built from 1961-1966. This represented an investment of over $1.5 billion, most of which came from private enterprise. This rapid rate of growth is expected to continue as new investors continue to enter the field.

One source of investment has been the expansion of existing facilities.[32] The primary source of investment is from the new firms entering the industry. Such established firms as Holiday Inns of America, Inc. and the Sheraton Corporation have expanded into the field, and several new corporations have entered the field on a national scale. A

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[30]Leon Bernstein, "E.C.F. Report on Impact of Medicare," Modern Nursing Home, Vol. 21, No. 6 (November/December, 1967), pp. 82-85, 125.

[31]"Nursing Homes Offer an Investment Lure," Business Week (July 23, 1966), pp. 113-114.

[32]Refer to Leon Bernstein, pp. 83-84.

major effect of these new firms entering the industry is the injection of new ideas, attitudes, and philosophy toward marketing.[33] Holiday Inns of America, Inc. and Sheraton Corporation have been successful in marketing their present product and expect to apply many of the same basic concepts in the nursing home field.

Medicare is affecting many other aspects of the nursing home industry. As Medicare pays a major portion of a patient's bill, price is declining in importance as a competitive tool since patients do not have to be price-conscious under Medicare. Another effect on the marketing of nursing homes has been the increasing of the size of the market for the industry. Now, more people can afford a nursing home, and thereby the demand for nursing homes has increased.

With the passage of Medicare, the Federal Government has assumed a dominant role in the nursing home industry. The future growth and development of the industry will be directly related to the policies that the Federal Government establishes relevant to the industry.

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[33]Refer to Ken Eymann, "The Medicenters Story," Professional Nursing Homes, Vol. 10, No. 2 (February, 1968), pp. 10-18, and "Its Happening at Extendicare," Professional Nursing Home, Vol. 10, No. 6 (June, 1968), pp. 11-26.

ECONOMIC CHANGES RELEVANT TO THE AGED

Economic conditions have changed substantially in the past one hundred years. Giant corporations have developed to dominate the economy, and this has brought about a change in the source of employment of the population from being self-employed to employment by others. As corporations began to dominate the working years of a person, the years after employment were also affected, and the concept of retirement has changed. These changes began during what is popularly referred to as the Industrial Revolution.

GROWTH OF GIANT CORPORATIONS

The Industrial Revolution, which began in England during the eighteenth century, was not fully felt in this country until after the Civil War. This signaled a change from individual home control of production to centralized factory methods. The technological revolution required large expenditures for capital equipment, and this necessitated a concentration of capital and resources. This concentration resulted in the growth of giant corporations and the decline of family control over jobs and property.

Under the old apprenticeship system, one took pride in his workmanship and identification with the material, process,

or product. The system of mass production in the giant corporation was impersonal, and the skills necessary no longer needed years of experience and training. The worker became dependent on the corporation for various aspects of his life, including his years after leaving the corporation.

This shift from being independent in old age to dependency on the giant corporation, or on the government, has resulted in the need for institutional solutions to the problems facing the aged. As corporations and the government assumed a role in the life of the aged, institutions arose to satisfy the needs, not only of the aged, but also of the corporations and the government

CHANGE IN RETIREMENT POLICIES

The shift from employment of self to employment by others has affected retirement policies in this country. At the turn of the century, retirement was gradual so that a person slowly phased into retirement. In 1900, there was only three years' difference between life expentancy and work life expectancy.[34] Retirement was brief, as death came

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[34]U. S. Department of Labor, The Length of Working Life for Males, 1900-1960, Manpower Report No. 8, Washington, D.C., July, 1963, pp. 7-8.

shortly after retirement.

As giant corporations developed and unions grew in power, compulsory retirement at arbitrarily selected ages became common. The retirement rate has increased substantially, especially in recent years. In 1950, 8.3 per cent of men left the labor force between their 64th and 65th birthdays. This percentage had increased to 23.4 per cent by 1963.[35]

With the modern improvements in medical care, the person retiring at age 65 can look forward to 12.9 years of life.[36] The retiree no longer faces death shortly after retirement, but his early retirement starts a period of slow degeneration.

As the length of time between retirement and death has increased, long-term concepts regarding the aged were needed. No longer did short-term concepts of care of the aged satisfy their needs. Long-term care facilities developed to provide the aged with care as they slowly degenerated. The nursing home developed to provide this long-term care of the aged.

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[35]Ibid., pp. 11-12.

[36]Arnold M. Rose, "Aging and Social Change: Implications and Challenges," University of Florida Institute of Gerontology, Social Change and Aging in the Twentieth Century, Vol. 13 (Gainesville, Florida: University of Florida Press, 1964), p. 4.

MEDICAL CHANGES AFFECTING THE AGED

Medical care has been in the process of change. There have been major improvements in medical knowledge in the field of geriatrics, the medical term concerning the aged. Life expectancy has increased from 47 years to more than 70 years since the turn of the century.[37]

The change of emphasis in medical care has been from infectious illness to chronic diseases. Infectious diseases are no longer a major threat, and people now survive to acquire chronic diseases. Chronic disease, such as heart disease, cancer, and arthritis, are usually long drawn-out illnesses. The proportion of the aged having one or more chronic diseases has increased from 46 per cent in 1901 to over 81 per cent in 1955.[38]

The aged are increasing in numbers because they are living longer. With heart transplants and other medical discoveries, the absolute number of aged will continue to

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[37]Dr. Morton Leeds, "Geriatric Implications of the Medical Revolution: A Biologic Pandora's Box," Journal of the American Geriatrics Society, Vol. II, No. 5 (May, 1963).

[38]Rose, op. cit., p. 2.

grow. With the increased medical knowledge, the costs of medical care have risen rapidly. The cost per day in the hospital is forecast to be $70 in 1970.[39] With this high cost of hospital care, substitutes for hospitals have developed. Nursing homes provide many of the same services a hospital provides at one-sixth the cost.[40] Nursing homes have developed to provide a low-cost, partial substitute for hospital care.

SOCIAL FORCES AFFECTING THE DEVELOPMENT OF NURSING HOMES

Various social changes have affected the development of nursing homes in the United States. These social changes have increased the need for institutional approaches to care for the aged.

FAMILY CHANGES

Changes in the family life cycle have helped stimulate the need for nursing homes. Since the turn of the century

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[39]"Hospitals Try to Cure a High-cost Syndrome," Business Week," (July 15, 1967), pp. 128-132.

[40]"planning Guide," Professional Nursing Home, Vol. 17, No. 12, (December, 1967), p. 43.

the family life cycle has been in a state of transition. The trend toward earlier marriage, smaller families, and longer life has affected the changing role of the aged in society.

Exhibit 2.5 summarized the changes in the life cycle from 1890 to 1980. The effect of these changes on the aged is that the husband-wife unit remains together longer, especially after the children have left the home. The 1890 couple spent 31 years together, whereas the 1959 couple spent 43 years together. With the children being born earlier, marrying younger, and the parents living longer, a 1959 couple expected 16 years together after the children left home. Death separated the 1890 couple prior to the children's leaving home.

After retirement and the children's leaving, a couple has many years together before death separates them. This period that a couple spends together has brought about changes in concepts on aging. A couple now has time to establish a new life together without children. There has been a definite increase in the aged having their own households, separate from their children.[41] This is one force bringing

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[41]Ethel Shonas, "Living Arrangements of Older People in the United States," Clark Tibbitts and Wilma Donahue, Social and Psychological Aspects of Aging, (New York: Columbia University Press, 1962), pp. 459-463.

about a decrease in the interdependence of aged parents and their children.

EXHIBIT 2.5

MEDIAN AGE OF HUSBAND AND WIFE AT SELECTED STAGES OF THE LIFE CYCLE OF THE FAMILY, FOR THE UNITED STATES: 1890 TO 1980

Stage of the Life Cycle of the Family	Median Age of Husband				Median Age of Wife			
	1890	1940	1959	1980	1890	1940	1959	1980
First Marriage	26.1	24.3	22.3	22.5	22.0	21.5	20.2	20.0
Birth of Last Child	36.0	29.9	27.9	29.5	31.9	27.1	25.8	27.5
Marriage of Last Child	59.4	52.8	49.2	51.5	55.3	50.0	47.1	48.5
Death of Spouse	57.4	63.6	65.7	68.5	53.3	60.9	63.6	65.5

Source: Paul C. Glick, David M. Heer, and John C. Beresford, "Family Formation and Family Composition: Trends and Prospects," Marvin B. Sussman, editor, Sourcebook in Marriage and the Family, second edition (Boston: Houghton Mifflin Company, 1963), pp. 30-40.

Another aspect of the changing life cycle is the change in the size of the family. The average size of the family has decreased during the past decades.[42] A smaller number

[42]Drake, op. cit., pp. 34-35.

of children are now available to look after the aged parents than at the turn of the century.

CHANGING IMPORTANCE OF KINSHIP

The primary effect on the aged of the changing family life cycle is more than just the numerical changes. The three-generation household has become less common as people moved from rural areas to urban centers. The close working environment of rural life necessitated close family ties, but with the growth of giant corporations and the movement to the cities, the importance of kinship has been declining.[43]

Many forces have combined to change the parents-children relationship. The interdependence between them has decreased, and the parents no longer expect their children to provide for them in their old age. As the dependence of aged parents on their children has decreased, other forces have developed to serve the aged. Industry, government, and philanthropic organizations have assumed many of the responsibilities that children formerly performed for their aged parents. In housing, financial support, and medical care, the government

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[43] Leonard Broom and Philip Selsnick, Sociology: A Text with Adapted Readings, (Evanston, Illinois: Row, Peterson and Company, 1956), p. 39.

and free enterprise now provide many of the needs of the aged that their children used to provide for.

SUMMARY OF THE EVOLUTION OF NURSING HOMES

The development of nursing homes has been affected by interrelated forces that have combined to create a need for nursing homes to fill. Demographic changes have brought about a large and diverse population segment. This segment now includes many couples living together, separate from their children. The children are no longer readily available to care for their aging parents. Medicine has been able to control infectious diseases, but people now survive to the stage of chronic diseases. The chronic diseases require long-term care of the aged, which is different from the short-term medical needs of infectious diseases. The high cost of hospital care has stimulated the need for substitutes to hospitals.

The shift from employment of self to employment by others has practically eliminated the chance for gradual retirement. Total retirement forces dependence on pensions and other non-working sources of income.

Social forces have brought about an institutional approach to retirement. Institutions now perform many of the functions which the aged parent's children and society used to perform.

The emergence of the Federal Government into an active role in the care of the aged affected both the growth and shape of the nursing home industry. Restrictions of the original Social Security Act stimulated the development of private institutions. The 1950 amendments to the Social Security Act upgraded the standards of the industry, and "Medicare" stimulated new investment in the industry.

The combination of these five forces -- demographic, governmental, medical, economic, and social -- has brought about the need for long-term care facilities for the aged. The interaction of these forces is directly responsible for the existence of the industry in its form today and its form in the future.

CHAPTER III

THE AGED CARE INDUSTRY IN FLORIDA

The aged care industry has been defined as all institutions and facilities providing medical and/or custodial care to persons sixty-five and over. This chapter provides a background study of this industry, with primary emphasis on the nursing home field. Selected aspects of the aged care industry were analyzed to provide a framework from which to analyze the marketing strategy of nursing homes.

The nursing home industry was the primary part of this analysis, although various other segments of the aged care industry were analyzed. This chapter includes a characterization of the nursing home industry as it currently exists in Florida and an analysis of the use of these facilities. Along with the analysis of the use of nursing home facilities, the financing of patient care in nursing homes was examined. The need for nursing home beds in Florida was projected and combined with supply and use statistics. The various counties in Florida were then classified with respect to the net need for nursing home beds.

AGED CARE FACILITIES IN FLORIDA

There are basically four types of facilities that make up the aged care industry. They are hospitals, nursing homes, homes for the aged, and home care programs. Each of these facilities provides medical and/or custodial care to persons aged sixty-five and over.

The degree and extent of care provided the aged varies among these four facilities. These facilities can be classified on a spectrum as to the amount of care provided. At one extreme is the hospital, which offers a large amount of services to its patients. Then comes the nursing home on the spectrum, followed by homes for the aged, where the care provided is minimal. Home care agencies provide care on a part-time basis only in a person's residence, and they are at the opposite extreme of the amount of care provided by a hospital.

In analyzing the marketing strategy of nursing homes, the total competitive environment needs to be examined. Each of the above four facilities is in one way or another in competition with the others. Nursing homes in planning their marketing strategy need to recognize who their competitors are and how they can most effectively compete with them.

Each of the four facilities that comprise the aged care industry is discussed in the following sections.

HOSPITALS

As of December 31, 1966, there were 178 hospitals in Florida providing 25,069 hospital beds.[1] Fifty-nine counties have from one to twenty-four hospitals, representing from twenty-five to 5,169 beds per county. Hospitals have a wider geographical distribution than nursing homes, even though there are almost one hundred less hospitals than nursing homes. Hospitals are larger than nursing homes on the average, with a mean size of 149.8 beds compared with the mean size of nursing homes, which have sixty-seven beds.

The number of nursing home beds in a county is closely related to the number of hospital beds in the county. There is a positive correlation coefficient of .9663 between the number of hospital beds in a county and the number of nursing home beds in a county.[2] This close relation between the supply

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[1]University of Florida Bureau of Business and Economic Research, Florida Statistical Abstract, 1968 (Gainesville, Florida: University of Florida, 1968), p. 57.

[2]The correlation coefficient is a statistical estimate of the degree of closeness of the relationship between two variables. The closer the coefficient is to one, the closer the relationship of the two variables. The closer the value is to zero, the less the degree of relationship between the two variables. For a description of correlation analyses see any basic statistics text or see: Mordecai Ezekiel and Karl

of hospitals and the supply of nursing homes exists because hospitals and nursing homes are not only substitutes for each other, but also complements to each other. Hospitals have evolved into primarily short-term care institutions, whereas nursing homes cater primarily to long-term patients. As specialists in long-term care, nursing homes can usually provide this type of care more effectively and efficiently than hospitals. The hospital, likewise, being specialists in short-term care, provides services that nursing homes cannot provide.

Nursing homes need to operate in close cooperation with local hospitals in order that the two may complement each other rather than act as competitors. The demand for nursing home care is directly related to the demand for hospital care operating in the same market area.

NURSING HOMES

Nursing homes follow closely behind hospitals on the spectrum with regard to the amount of care provided for the aged. The amount of care varies substantially between nursing homes, but they all provide at least a minimal amount of nursing care. The care provided includes custodial care,

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A.Fox, Methods of Correlations and Regression Analysis, (New York: John Wiley & Sons, Inc., 1961).

such as room and board, and nursing care. In addition, other services are often provided such as physical therapy, occupational therapy, and various specific medical services, such as X-ray and laboratory services.

The evolution of nursing homes is directly related to hospitals. Hospitals have evolved over the recent years as institutions specializing in short-term medical care, whereas nursing homes have evolved as institutions specializing in long-term medical care. By specializing on the long-term care segment of the medical care market, nursing homes have evolved as a less expensive substitute for hospital care. By limiting the amount of care nursing homes provide, nursing homes have been able to effectively and efficiently provide long-term care for the aged.

Nursing homes have evolved by appealing to a particular niche of the medical care market. As nursing homes have more narrowly defined their market, other types of facilities have evolved to appeal to a niche nursing homes have neglected.

HOMES FOR THE AGED

Homes for the aged are institutions providing a minimal amount of service to their residents. The Board of Health defines homes for the aged as "a home providing domiciliary and custodial service for persons who are independent or only

require some personal assistance."[3] There are sixty-seven such facilities in Florida with a capacity for 4,334 persons.[4] Not all institutions operating as homes for the aged are licensed as such by the State. Many such facilities are licensed as hotels or boarding homes, but cater primarily to the aged. For this reason, it is difficult to generalize about the effect of this aged care industry on the nursing home industry.

Homes for the aged appear to be an important present and potential competitor to the nursing home industry. Whereas nursing homes have evolved partly as inexpensive substitutes for hospital care, homes for the aged are developing as inexpensive substitutes for nursing homes. Many homes for the aged are operating in conjunction with a nursing home. In these institutions, the nursing home is a small part of the home for the aged's total operation, and it operates like an infirmary to the home's residents.

The competition from homes for the aged is relatively recent, but it is potentially a more important factor in the future. Nursing homes can compete effectively against homes

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[3]Florida State Board of Health, Rules and Regulations for Health Facilities, Jacksonville, Florida, 1967, p. 203.

[4]Florida State Board of Health, Florida State Board of Health Annual Report, 1967, Jacksonville, Florida, 1968.

for the aged, but they need to be cognizant of the existence of these homes in establishing their marketing strategy.

HOME CARE PROGRAMS

With the passage of Medicare, emphasis has been placed on care of the aged in their own residences. The idea was to provide intermittent care at a person's residence, and included in this care are such services as domestic chores, running errands, nursing care, and companionship.[5] Home care programs seek to provide personal care outside an institution. This service allows a person to leave a nursing home earlier than originally scheduled, since care is provided at home. This reduces the total cost of care provided, since a person is not in an institution as long.

Home care programs are not yet an important factor affecting the competitive environment in which nursing homes operate. With Federal subsidies, the home care programs are growing, and nursing homes have the opportunity of either competing with these programs or joining in participation in the programs.[6]

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[5]Refer to Robert C. Linstrom, "A New Challenge to Nursing Homes," Nursing Homes, Vol. 15, No. 12 (December, 1966), pp. 33-35 or to Sammuel Zibit and Gerald N. Cohn, "Home Health Service in a Nursing Home," Nursing Homes, Vol. 16, No. 5 (May, 1967), pp. 19-22.

[6]Florence E. Logan, "Participation in Home Health Services," Nursing Homes, Vol. 17, No. 4 (April, 1968), pp. 13-15.

Home care programs are the final part of a "total" approach to the care of the aged. A person after receiving intensive care in a hospital is able to gradually phase himself back to normal activities by taking a step-by-step program from the hospital, to the nursing home, to the home for the aged, and finally to his own home under the care of a home care agency. To accomplish this objective of step-by-step return to normal activities, coordination between the various institutions and agencies is important. The Federal government is presently pushing for areawide planning in the care of the aged.[7] Nursing homes play a critical role in the gradual rehabilitation of the aged, and this role is an important consideration in the marketing policies a nursing home pursues. In determining the marketing strategy they follow, nursing homes need to be cognizant not only of their direct competition in the nursing home industry, but also of the present and potential competition from substitutes and complements of nursing home care.

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[7]Joseph A. Gallagher, "The Role of Areawide Planning of Health Facilities and Services," University of Florida Institute of Gerontology, Medical Care under Social Security: Potentials and Problems, Vol. 15 (Gainesville, Florida: University of Florida Press, 1966), pp. 87-98.

THE NURSING HOME INDUSTRY IN FLORIDA

This section of the chapter provides a statistical characterization of the nursing home industry in Florida. The statistics used in this section were obtained from responses to the questionnaire, the Annual Reports of the Florida State Board of Health,[8] and from the Florida State Plan published by the Division of Community Hospitals and Medical Facilities of the State of Florida.[9] The marketing environment that nursing homes operate in was analyzed by first establishing the size of the market area for nursing homes. Then the industry was examined with respect to size of nursing homes, ownership of nursing homes, and number of nursing homes.

AREA SERVED BY FLORIDA NURSING HOMES

The competitiveness of the environment in which nursing homes operate is directly related to the number of competitors

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[8]Florida State Board of Health, Florida State Board of Health Annual Reports, 1960 to 1967, Jacksonville, Florida, 1960 to 1967.

[9]State of Florida, Division of Community Hospitals and Medical Facilities, Florida State Plan, 1969, Tallahassee, Florida, 1969.

operating in the same market area. In order to establish the number of competitors that a firm is in competition with, the size of the market area was established. Nursing home administrators were asked to estimate the per cent of their patients whose residence prior to entering their home was within various classifications. As Exhibit 3.1 shows, the vast majority of patients in a nursing home come from within twenty-five miles of the nursing home.

EXHIBIT 3.1

DISTANCE FROM NURSING HOME OF PATIENT'S RESIDENCE PRIOR TO ENTERING HOME, FLORIDA, 1968

	Per cent
Less than ten miles from home	57%
Ten to twenty-five miles from home	30
Over twenty-five miles from home	13
Total	100%

Source: Mail survey of Florida nursing home Administrators

As the above table shows, approximately 87 per cent of patients in a nursing home come from within twenty-five miles of the home. In 1965, 185 nursing homes around the country that were FHA assisted were surveyed with regard to

their source of patients.[10] These nursing homes estimated that approximately 79 per cent of their patients, at the time of the survey, had been living within a twenty-mile radius of the nursing home prior to entering the home.[11] Based on the above two surveys, the market for nursing homes is mostly local, and nursing homes are primarily in competition with homes within their immediate area.

In order to analyze the structure of the nursing home industry, the total market must be broken down into numerous local markets. In this study the method of defining the local market was the use of political boundaries. The sixty-seven counties in Florida were each considered separate market areas. It was realized that many weaknesses were inherent in the use of political classifications, but no other method of classification was feasible with the information available.

Of the sixty-seven counties in Florida, twenty-nine have no nursing homes. The remaining thirty-eight counties have from one to fifty nursing homes representing from nine to 3,709 nursing home beds. As of December, 1967, there were

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[10]U. S. Department of Housing and Urban Development, Federal Housing Administration, Study of FHA Assisted Nursing Homes, Washington, D.C., 1966.

[11]Ibid., p. 9.

277 nursing homes with a bed capacity of 18,339 in Florida.[12]

NUMBER OF NURSING HOMES

In this section, nursing homes are characterized with respect to both the total number of nursing homes and the total number of nursing home beds. The current characteristics of the homes are presented, and the trend of the industry in Florida is examined.

Total Number of Nursing Homes and Nursing Home Beds

As of December 31, 1967, there were 277 nursing homes licensed in Florida with a total capacity of 18,339 beds. Exhibit 3.14 provides a statistical summary of the thirty-eight counties in Florida with nursing homes. There was a range from one to fifty of the number of nursing homes in the thirty-eight counties but the median number of homes was only two. Sixty-six per cent of the counties have three or fewer homes, and only four counties have over twenty nursing homes. The typical county in Florida is characterized as having a small number of nursing homes.

Change in the Number of Nursing Homes, 1960-1967

The net number of nursing homes in Florida has not grown very rapidly since 1960. As shown in Exhibit 3.2, there was

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[12]Florida State Board of Health, Annual Report, 1967, op. cit.

an 18 per cent increase in the number of nursing homes during the eight year period. This was a net average annual increase of approximately 5.4 nursing homes.

EXHIBIT 3.2

TOTAL NUMBER OF NURSING HOMES, NURSING HOME BEDS, NUMBER OF NEW HOMES AND NUMBER OF HOMES CLOSED, FLORIDA, 1960-1967

Year	No. of New Homes Added	No. of Homes	No. of Homes Closed	No. of Beds	Average Size
1960	--	234	5	7,742	33
1961	14	224	24	7,843	35
1962	34	248	10	9,553	39
1963	25	263	10	10,975	42
1964	27	274	16	13,462	49
1965	21	277	18	14,983	54
1966	1	262	14	16,320	62
1967	27	277	12	18,339	66
Total	149		109		

Source: Florida State Board of Health, Annual Report, 1960-1967, (Jacksonville, Florida: Florida State Board of Health.)

An important aspect of the growth in the number of nursing homes was the number of nursing homes closed during the year. As Exhibit 3.2 shows, there was an average of 13.6 nursing homes ceasing operation during the eight years from 1960 to 1967; a total of 109 ceased operations. There was an average of 21.3 new homes opened during the seven year period from 1961 to 1967; this was an increase of 149 new

homes in the eight year period. Assuming that these new homes are all still in operation, 54 per cent of the nursing homes in Florida have been built since 1961. This growth of new nursing homes is typical of the industry throughout the country.[13]

EXHIBIT 3.3

TOTAL NUMBER OF NURSING HOMES IN FLORIDA BY SIZE OF HOME, 1967

Size of Home	Total no. of Homes	Total no. of Beds
1-25	51	899
26-50	72	2,689
51-100	100	6,836
101-200	47	5,942
Over 200	7	2,473
Total	277	18,339

Source: State of Florida, Florida State Board of Health Annual Report, 1967, (Jacksonville, Florida: Florida State Board of Health, 1968).

The growth in the bed capacity of nursing homes has been more rapid than the growth in the number of nursing homes.

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[13]"Nursing Homes Offer an Investment Lure," Business Week (July 23, 1966), pp. 113-114.

From 1960 to 1967, there was a net increase of 10,597 additional nursing home beds in Florida, or an increase of 137 per cent. Since the net number of nursing homes increased only 18 per cent during this same period of time, the growth in the number of beds has come from an increase in the average size of nursing homes. From 1960 to 1967, the average size of Florida nursing homes has doubled from thirty-three to sixty-six beds per home.

SIZE OF HOMES

Nursing homes in Florida vary in size from less than ten to over four hundred beds. The average size in Florida was sixty-six beds, which was larger than the national average of forty-two beds.[14] The increase in the average size of nursing homes resulted primarily from the construction of larger homes, rather than the expansion of existing facilities. While the average size nationally was forty-two beds in 1966, the average size of nursing homes reported under construction during the same year was 65.3.[15]

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[14] American Nursing Home Association, "Fact Sheet #3" (Washington, D.C.: American Nursing Home Association, 1967), p. 3.

[15] Ibid.

Exhibit 3.3 classifies nursing homes by the number of beds the nursing home was licensed to handle. Forty-four per cent of Florida nursing homes had less than fifty beds, and these 123 homes had only 20 per cent of the total bed capacity in Florida. Only 19 per cent of the nursing homes in Florida had over a one hundred bed capacity, but these fifty-four homes had 43 per cent of the bed capacity of the State. The industry is characterized as being primarily one of small firms, but with a limited number of large firms dominating the total nursing home bed capacity.

OWNERSHIP OF HOMES

The vast majority of nursing homes were privately owned, and in Florida 84 per cent of the homes were proprietary institutions. Exhibit 3.4 provides a breakdown of the type of ownership of nursing homes in Florida, and these statistics coincide fairly closely with nation-wide averages. The most current national study of the ownership of nursing homes was made in 1963, and the estimate made then was that 87 per cent of the nation's nursing homes were proprietary institutions.[16]

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[16]U. S. Public Health Service, Nursing Home Utilization and Costs in Selected States, Health Economic Series No. 8, Washington, D.C., 1968, pp. 3-4.

EXHIBIT 3.4

OWNERSHIP OF NURSING HOMES IN FLORIDA, 1967

Type of Ownership	No. of Homes	No. of Beds	Average Size
Proprietary	231	15,258	66
Church	27	1,428	53
Public	9	877	98
Other	10	776	78
Total	277	18,339	295

Source: State of Florida, Florida State Board of Health Annual Report, 1968 (Jacksonville, Florida: Florida State Board of Health, 1968).

USE OF NURSING HOME FACILITIES

The use of nursing home facilities is limited to a small segment of the total population. The population segment that nursing homes appeal to is delineated primarily along the lines of age. In addition to establishing who uses nursing homes, the actual use rates of nursing homes in Florida was examined. Occupancy rates were analyzed with respect to selected characteristics of nursing homes and also by counties in Florida.

DEMOGRAPHIC CHARACTERISTICS OF NURSING HOME RESIDENTS

The use of nursing home facilities was delineated along the lines of age, sex, and color. Age was the primary method

of delineating the use of nursing home facilities. This section examines selected demographic characteristics of nursing home patients and analyzes these statistics with corresponding statistics for the State of Florida.

Distribution of Patients by Age, Sex, and Color

Exhibit 3.5 classifies nursing home residents by age, sex, and color for both national averages and the State of Florida. The Public Health Service, in their 1963 survey, included not only nursing homes, but also "personal care homes." Forty-eight per cent of the facilities surveyed by the Public Health Service were nursing homes, and 22 per cent were homes providing personal care only and no nursing service. The remaining 30 per cent of the facilities fell somewhere between these two classifications.[17] Due to the inclusion of personal care homes in the Public Health Service survey, the results were not truly representative of the nursing home industry. Even with this limitation, the results of this survey provide the most complete and current national statistics available on the nursing home industry.

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[17]For a complete description of the sample see: U. S. Public Health Service, Characteristics of Residents of Institutions for the Aged and Chronically Ill, National Center for Health Statistics, Series 12, No. 2, Washington, D. C., 1965, pp. 2-3, 39-49.

EXHIBIT 3.5

PER CENT DISTRIBUTION OF NURSING HOME RESIDENTS BY AGE, SEX, AND COLOR, UNITED STATES-1963, FLORIDA-1967

	National[1]	Florida[2]
Age		
Under 65 years	12%	3%
Over 65 years	88	97
	100%	100%
Sex		
Male	34%	31%
Female	66	69
	100%	100%
Color		
White	96%	95%
Non-White	4	5
	100%	100%

[1]Source: U. S. Public Health Service, "Characteristics of Residents of Institutions for the Aged and Chronically Ill," National Center for Health Statistics, Series 12, Number 2 (Washington, D.C.: Public Health Service, 1965), pp. 4,19.

[2]Source: Mail Survey of Florida Nursing Home Administrators.

As Exhibit 3.5 shows, the typical nursing home patient was past age sixty-five, female, and white. Age was the single most effective characteristic to delineate nursing home patients from the general population. This fact is further substantiated by Exhibit 3.6, where the proportion of various age segments in institutions is shown. There was a close relationship between age and the proportion of the age group

in nursing and personal care homes. Based on these statistics, the market for nursing homes can be defined primarily as those persons aged sixty-five and over. Approximately four per cent of this population segment was in nursing and personal care homes.

EXHIBIT 3.6

NUMBER OF RESIDENTS IN NURSING HOMES AND PERSONAL CARE HOMES PER 1,000 POPULATION 20 YEARS AND OVER: UNITED STATES, APRIL-JUNE, 1963

	Total	Sex		Color	
		Male	Female	White	Non-White
All persons over 20	4.5	3.2	5.6	4.8	1.7
20-64 years	.6	.7	.6	.6	.6
65-74 years	7.9	6.8	8.8	8.1	5.9
75-84 years	39.6	29.1	47.5	41.7	13.8
85+ years	148.4	105.6	175.1	157.7	41.8

Source: U. S. Public Health Service, "Characteristics of Residents of Institutions for the Aged and Chronically Ill," National Center for Health Statistics, Series 12, Number 2 (Washington, D.C.: Public Health Service, 1965), p. 4.

The difference between the proportion of the two sexes in nursing homes is partly accounted for by the sex differences in the older age segments of the population. In

Florida, the 1965 estimated population aged sixty-five and over was 720,000.[18] Forty-eight per cent of this group was male and the remaining 52 per cent was female.

Only a small per cent of the residents of nursing homes was non-white. This factor accounted for partly by the difference in longevity between the two races. Also, as shown in Exhibit 3.6, the difference between white and non-white with regard to the proportion of various age groups in nursing and personal care homes gets greater for the higher age groups. This proportion of the non-whites in nursing and personal care homes was partly a result of the lower economic status of non-whites.

Nursing Homes and the Age Composition of Florida

Florida's 1967 estimated population was 7,201,000 of which 13.1 per cent, or 776,000, were past the age of sixty-five. Among the counties of Florida the per cent of the population aged sixty-five and over varied from 5.6 to 25.9 per cent. Various areas in Florida have attracted large proportions of the aged population, and the nursing home industry is directly affected by this fact.

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[18]State of Florida, Division of Community Hospitals and Medical Facilities, Florida State Plan, 1969, op. cit., p. 20.

Thirty-eight counties in Florida have one or more nursing homes. There is a high positive correlation in the number of nursing home beds in a county and the number of persons age sixty-five and over. The coefficient of correlation of .9912 indicates that a close relationship exists between nursing homes and the aged population. The correlation between the number of nursing home beds and the total county population was not as high as the above correlation.

One statistic used for analysis of nursing home market demand was the number of nursing home beds per one thousand population aged sixty-five and over. Exhibit 3.14 gives this information on the counties in Florida. For the state in 1967, there were 23.9 beds per one thousand persons aged sixty-five and over. The relation of the population aged sixty-five and over to nursing homes was an important step in analyzing the market demand for nursing homes.

OCCUPANCY RATES OF NURSING HOMES

Statistics on the per cent of nursing home beds occupied in nursing homes are summarized in Exhibits 3.7, 3.8, and 3.9. The national estimates of occupancy were obtained from Professional Nursing Home, which surveyed 892 nursing homes nationwide for their statistics. The Florida Estimates for occupancy were obtained from information provided in the Florida State

Plan.[19]

EXHIBIT 3.7

PATIENT DAYS AND OCCUPANCY RATES FOR NURSING HOMES BY SIZE OF HOME: UNITED STATES AND FLORIDA, 1962

	Size of Home			
	Less than 50 beds	50-99 beds	Over 99 beds	Total
Florida (1)				
Number of Homes	78	76	46	200
Number of beds	2,318	5,185	6,733	14,236
Patient days	748,075	1,646,062	1,982,749	4,376,886
Average Occupancy Rate	88.4	84.1	80.7	84.2
United States (2)*				
Proprietary	93.6	91.7	91.7	91.7-93.6
Non-Profit	94.9	96.8	96.2	94.9-9.62

*Occupancy rates for the United States were available classified by both size of home and ownership but not separately.

(1) Source: State of Florida, Florida State Plan, (Tallahassee, Florida: Division of Community Hospitals and Medical Facilities, 1969), pp. 75-262.

(2) Source: "Planning Guide", Professional Nursing Homes, Vol. 9, No. 12. (December, 1967), p. 42.

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[19]The Florida State Plan gives the number of patient days in 200 nursing homes in Florida for 1967. Patient days are the number of patients in a nursing home each day. When given on an annual basis, as was the case in the Florida State Plan, the patient days for all 365 days in 1967 were summed together. The total possible number of patient days for a nursing home in a year is 365 times their number of beds. The average occupancy rate for Florida nursing homes was obtained by dividing the total possible patient days for a nursing home into the actual number of patient days.

EXHIBIT 3.8

PATIENT DAYS AND OCCUPANCY RATES FOR NURSING HOMES BY TYPE OF OWNERSHIP OF THE HOME: UNITED STATES AND FLORIDA, 1967

	OWNERSHIP		
	Proprietary	Non-Profit	Total
Florida (1)			
Number of Homes	160	40	200
Number of Beds	11,413	2,823	14,236
Patient Days	3,442,672	934,214	4,376,886
Average %	82.6	90.7	84.2
United States *(2)	91.7-93.6	94.9-96.2	91.7-96.2

*United States statistics were classified by both ownership and size of home. Ranges were provided for the various sizes of classification.

(1) Source: State of Florida, Florida State Plan, (Tallahassee, Florida: Division of Community Hospitals and Medical Facilities, 1969), pp. 75-262.

(2) Source: "Planning Guide," Professional Nursing Homes, Vol. 9, No. 12, (December, 1967), p. 42.

EXHIBIT 3.9

NUMBER AND PER CENT OF FLORIDA COUNTIES CLASSIFIED BY OCCUPANCY RATES, 1967

Occupancy Rate	Number of Counties	Per Cent
Less than 60	2	6%
60-69	3	9
70-79	5	15
80-89	14	40
99-100	10	30
Total	34	100%

Source: State of Florida, Florida State Plan, (Tallahassee, Florida: Division of Community Hospitals and Health Facility, 1969), pp. 75-262.

As seen in the Exhibits 3.7 and 3.8, the Florida occupancy rates were below national statistics. Differences in computational techniques was one factor accounting for this difference. Another factor was that the Florida statistics were occupancy rates for the entire year, and the Professional Nursing Home estimates were occupancy rates at the time of the survey and not annual averages. Despite the differences in absolute values, the statistics agree with regard to proportionate differences.

Exhibit 3.7 indicates that the smaller the nursing home, the higher the average occupancy rate. Numerous factors account for this condition. Larger nursing homes were on the average newer institutions and had not had sufficient time to fill to capacity. Smaller homes, being established longer on the average, had reached their capacity and were able to maintain this patient capacity.

Ownership of the nursing home was also related to occupancy rates. Non-profit nursing homes, including government, church, and other non-profit homes, had a higher rate of occupancy than proprietary nursing homes. This difference in occupancy based on ownership was explainable. Many of the non-profit facilities were welfare-type institutions, where the patients pay either a nominal amount or nothing at all to stay in the nursing home. Many of the other non-profit homes

provide care for persons unable to pay for the care themselves. Many persons in non-profit homes were unable to afford care in a proprietary institution.

Exhibit 3.9 summarizes the thirty-four counties providing information on occupancy. Twenty-five per cent of the counties had less than 80 per cent average occupancy in 1967. The Federal Housing Administration in a 1966 survey estimated that the mean and median break-even point was an occupancy of approximately 75 per cent.[20] Using this break-even point, between fifteen and thirty nursing homes were operating below the break-even point in Florida in 1967.

FINANCING PATIENT CARE IN NURSING HOMES

There are essentially three sources of financing by which a patient pays his bill. Personal sources, such as income and use of assets, is one major source. The other major source is public financing of nursing home care. This source has grown rapidly in importance and includes not only Medicare, but also Medicaid, state, and local public assistance programs. The third source from which payment comes is relatively new but is growing in importance. This third source is the use of health insurance programs to cover

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[20]U. S. Department of Housing and Urban Development, op. cit.

nursing home care. This source is so new that limited information is available on it. Since only limited information is available on these insurance programs and since they pay for only a very small portion of the total amount spent on nursing home care, only limited discussion is provided on them. The primary emphasis is on public and private sources of payment.

PRIVATE SOURCES OF FINANCING

Private sources formerly were the primary means of financing nursing home care. As shown in Exhibit 3.10, private sources have increased in absolute terms since 1960 but have declined in relative importance. The beginning of Medicare coverage of nursing home care on January 1, 1967 was the primary reason for the large change both in absolute and relative terms from 1966 to 1967.

Private sources were mainly consumers, rather than philanthropic organizations. Philanthropic expenditures on nursing home care averaged approximately three per cent of total private expenditures.[21] Consumer sources of financing included personal income, use of assets, and assistance from relatives.

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[21]U. S. Department of Health, Education, and Welfare, "Public and Private Expenditures for Health, Fiscal Years 1965-68 and Calendar Years 1965-67," Research and Statistics Note, No. 22, Washington, D. C., 1968.

EXHIBIT 3.10

SOURCE OF FUNDS FOR NURSING HOMES CARE: UNITED STATES, 1960-1967

Year	Total (Millions)	Private (Millions)	Private (Per Cent)	Public (Millions)	Public (Per Cent)
1967	$1,858	$666	35.8%	$1,192	64.2%
1966	1,502	831	55.3	671	44.7
1965	1,324	830	62.7	494	37.3
1964	1,214	834	68.7	380	31.3
1963	891	554	62.2	337	37.8
1962	695	420	61.4	275	39.6
1961	606	432	71.3	174	28.7
1960	526	419	79.5	108	20.5

Source: U. S. Department of Health, Education, and Welfare, "National Health Expenditures, 1950-1966," Research and Statistics Note, Note No. 3, Washington, D.C., February, 1968.

U. S. Department of Health, Education, and Welfare, "Public and Private Expenditures for Health, Fiscal Years 1965-1968 and Calendar Years, 1965-1967," Research and Statistics Note, Note No. 22, Washington, D. C., November, 1968.

Personal Income

The average income of persons past age sixty-five was below the national average. In 1966, the median income for families in the United States was estimated at $7,436, and for families with the head of the household past sixty-five the median income was estimated at $3,645.[22] For unrelated

[22]U. S. Department of Commerce, Bureau of the Census, "Income in 1966 of Families and Persons in the United States," Current Population Reports, Series P-60, No. 53, December, 1967, p. 24.

individuals, the national median was $2,270, and for unrelated individuals past age sixty-five, the median was $1,443.[23]

Income statistics for persons sixty-five and over for Florida were not available, except the 1960 Census statistics. Due to major economic changes during the past ten years, these statistics from the 1960 Census were not of practical use in this analysis. One indicator of the income of persons sixty-five and over was the amount of Social Security payments in a county. This information was available on a current basis by county and is positively correlated with the number of nursing homes in the thirty-eight counties with homes. The correlation coefficient of the 1967 statistics on the number of nursing homes in a county and the amount of Social Security payments to the county was .9651. This high correlation also results from the population of aged in Florida counties. Personal income, either total personal income or per capita income, does not correlate well with the number of nursing home beds.

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[23] Ibid.

Use of Assets

The use of assets was the primary source of personal funds available to pay for nursing home care. The use of assets, primarily savings, accounts for approximately 80 per cent of the total private sources of funds for nursing home care.[24] The use of assets to pay for nursing home care has to be of major importance as a private source of payment, since the aged's income is so low.

Use of assets was an important source of funds for the aged in their regular budget. For families with the head over sixty-five, 17 per cent of the family's total receipts, or an average of $761, came from a decrease in assets. Where the head of the family was under sixty-five years, only 10 per cent or $901, came from a decrease in assets.[25]

Besides the actual use of assets of the aged, the potential income from the use of assets must be considered. The median value of the assets held by couples sixty-five and over was $11,180, for non-married men the median was

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[24]Coleman and Company, The Nursing Home Market (New York: Coleman and Company, 1968), p. 16.

[25]Helen H. Lemale, "The Impact of Rising Prices on Younger and Older Consumers," U. S. Bureau of Labor Statistics, Report No. 238-2, December, 1963.

$2,900, and for non-married women the median was $3,285. More than a third of the married couples had assets of more than $15,000.[26] If the assets of all the aged over sixty-five were converted to income, prorated over the expected life of the holder, their income would be increased substantially. If the aged's owned home was excluded, the median income would be increased 10 per cent by prorating the aged's assets over their expected life. By including the equity in their owned home, the median income would increase more than 30 per cent.[27]

In projecting the use of private sources of funds for nursing home care, accurate projections were difficult to estimate. Statistics on the financial conditions of the aged were not available on a state or county basis, and projecting national statistics to a state or local basis was risky and not very accurate. Therefore, the above discussion on private sources of financing for nursing home care was on a general basis. The objective of the above section

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[26]L. D. Platley, "Assets of the Aged," Social Security Bulletin, Vol. 27, No. 1, January, 1964, pp. 4, 13.

[27]Janet Murray, "Potential Income from Assets: Findings of the 1963 Survey of the Aged," Social Security Bulletin, Vol. 22, No. 12, December, 1964, p. 11.

was to show what the private sources of funds were and the nature of them.

PUBLIC SOURCES OF FINANCING

Public sources for financing nursing home care have grown rapidly in recent years. As shown in Exhibit 3.11, public sources of funds for nursing home care have increased substantially since 1960, both in absolute and in relative terms. In absolute terms, public expenditures on nursing home care have increased over one thousand per cent in the eight year period from 1960 to 1967. In relative terms, the proportion of public expenditures, versus private expenditures, increased from 20.5 per cent of the total source of funds in 1960 to 64.2 per cent in 1967.

There are essentially two sources of public funds for nursing home care: Federal sources and the combination of state and local sources. State and local government agencies cooperate in providing funds, acting as complements to each other. For this reason, state and local sources are considered as essentially only one source. Until recent years, the primary public sources of funds were the state and local government, but with the passage of Medicare the role of the Federal government in financing patient care in nursing homes has grown in importance.

EXHIBIT 3.11

NURSING HOME EXPENDITURES BY PUBLIC SOURCES:
FISCAL YEARS 1964-65 TO 1967-68

Fiscal Year	Total (Millions)	Federal (Millions)	Federal (Per Cent)	State and Local (Millions)	State and Local (Per Cent)
1967-68	$1,463	$892	61.0%	$571	39.0%
1966-67	919	512	55.7	407	44.3
1965-66	604	276	45.7	328	54.3
1964-65	450	183	40.7	266	59.3

Source: U. S. Department of Health, Education, and Welfare, "Public and Private Expenditures for Health, Fiscal Years 1965-68 and Calendar Years 1965-67," Research and Statistics Note, Note No. 22, Washington, D.C., November, 1968.

Federal support for nursing home care has been increasing both absolutely and relatively. As shown in Exhibit 3.11, during the four year period following the fiscal year 1964-65, Federal expenditures on nursing home care have increased almost four hundred per cent to $892 million. Relative to state and local expenditures, the Federal share of public expenditures on nursing home care has increased from 40.7 per cent to 61 per cent during the four year period. Public expenditures are of two primary types, Medicare and public assistance programs. Medicare is exclusively a Federal program, but public assistance programs are the joint effort of Federal, state, and local agencies. These two programs,

Medicare and public assistance, are discussed in the following sections.

Public Assistance

Public assistance programs, often referred to as welfare, provided $1,127 million in the fiscal year 1967-68 for nursing home care. This amount was fairly evenly divided between Federal and state and local governments. Exhibit 3.12 shows the breakdown of public assistance for the fiscal years 1964-65 to 1967-68. The Federal role in public assistance for nursing home care has grown rapidly under the Kerr-Mills program. Under this amendment to the Social Security Act, the Federal government pays for the nursing home care of the "medically indigent" aged. The "medically indigent" includes those aged who can ordinarily pay for their food, shelter, and clothing, but who do not have sufficient resources to provide for medical care.[28] The states have a great deal of freedom in establishing the rules and regulations regarding the kind and extent of the services that are paid under the Kerr-Mills program.

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[28]For a more complete discussion of Federal public assistance programs for nursing home care see: H. E. Martz, "Medical Care for the Aged Under Public Assistance," Health, Education, and Welfare Indicators, March, 1963, pp. 5-16.

EXHIBIT 3.12

PUBLIC ASSISTANCE EXPENDITURES ON NURSING HOME CARE, FISCAL YEARS 1964-65 TO 1967-68.

Fiscal Year	Total (Millions)	Federal (Millions)	Federal (Per Cent)	State and Local (Millions)	State and Local (Per Cent)
1967-68	$1,127	$556	49.3%	$571	50.7%
1966-67	792	385	48.6	407	51.4
1965-66	590	261	44.3	328	55.7
1964-65	448	182	40.6	266	59.4

Source: U. S. Department of Health, Education, and Welfare, "Public and Private Expenditures for Health, Fiscal Years 1965-68 and Calendar Years 1965-67," Research and Statistics Note, Note No. 22, Washington, D.C., November, 1968.

The 1965 amendments to the Social Security Act provided for a new Federal program to finance nursing home care of the "medically indigent." The program, known as Medicaid, is financed jointly by state and Federal funds. The states determine the benefits and eligibility under Federal guidelines. Not all the states have joined in the Medicaid program, and Florida is one state yet to adopt the program. When Medicaid is adopted by the State of Florida, essentially all public assistance programs covering nursing home care will fall under the Medicaid program. This program is an important factor in the future of the nursing home industry in Florida, but is beyond the coverage of this chapter.

Medicare

Medicare legislation was passed in 1965, but did not take effect regarding nursing homes until January 1, 1967. Medicare covers most of a patient's cost in a nursing home for one hundred days. To be eligible, a person must have spent three days in a hospital prior to entering a nursing home and must need skilled nursing care. Not all nursing homes qualify for Medicare, and in Florida as of 1967, there were 139 nursing homes qualified with 11,069 beds. This represents about 60 per cent of the licensed nursing home beds in Florida.

Medicare covers practically all persons past sixty-five, and it is having a dramatic effect on the nursing home industry.[29] Medicare, unlike Medicaid and Federal public assistance programs, is directly under the control of the Federal government. The effects of Medicare are already far-reaching, and the future of the program is an important factor in the future growth and development of the nursing home industry.[30]

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[29]Leon Bernstein, "E.C.F's Report on Impact of Medicare," Modern Nursing Home, Vol. 21, No. 6, November/December, 1967. pp. 82-85, 125.

[30]Ibid.

Public sources of funds to cover nursing home care have expanded rapidly in recent years and hold a critical position in the future of the nursing home industry. A major effect of these programs was the expansion of the market for nursing homes by making many people now able to afford nursing home care. With the ready availability of financing of nursing home care to anyone in need of care, the market demand for nursing homes has been greatly expanded.

NEED FOR NURSING HOMES IN FLORIDA

In this section the need for nursing homes is examined with respect to the population segment defined as those persons aged sixty-five and over. The need for nursing homes was examined from three perspectives. First, the medical need of the over sixty-five population segment was examined. Second, the Federal government's method of projecting the market needs was studied, and third, private industrial projections were examined.

MEDICAL NEED FOR NURSING HOME CARE

Projecting the medical needs of persons aged sixty-five and over was a risky subject. The only known study usable for this type of projection was a 1958-59 survey made by the

U. S. Department of Health, Education, and Welfare.[31] This National Health Survey estimated that 44.3 persons per one thousand aged sixty-five and over were receiving some care at home and 24.8 persons per one thousand persons aged sixty-five and over were under constant or full-time care.[32]

Applying these rates to the population aged sixty-five and over in Florida gave one estimate of the number of persons who might need nursing home care. Applying the 44.3 per one thousand persons aged sixty-five and over to the 1967 estimate of Florida's sixty-five and over population, it was found that there were 34,377 persons in Florida who are currently receiving some care at home because of illness or disability. Not all of these people were in need of nursing home care, but they were part of the total potential market. This figure can be considered as the maximum potential market, and the actual market is something less than the rate of 44.3 per one thousand.

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[31] U. S. Department of Health, Education, and Welfare, U. S. National Health Survey, Persons Receiving Care at Home, United States, July, 1958 - June, 1959, Public Health Service Publication No. 584, Series B-28, Washington, D.C., 1961.

[32] Ibid., p. 2.

A more realistic rate to use in projecting need is the proportion of persons under constant or full-time care at home. Applying this rate of 24.8 persons per one thousand aged sixty-five and over gives 19,245 persons who can be considered prospects for a nursing home. This group of persons is more likely to seek nursing home care than the less handicapped group estimated above.

Exhibit 3.13 provides a county analysis of the medical needs of persons aged sixty-five and over. The county classification used was that adapted from the Florida State Plan, developed by the Board of Commissioners of State Institutions in Florida. Included in this Exhibit are the projected needs of the counties by the two approaches discussed in the following sections.

FLORIDA STATE PLAN

The Florida State Plan is a government study of the present system and future needs of hospitals and related health facilities in Florida.[33] The "State Plan" was designed for

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[33]State of Florida, Division of Community Hospitals and Medical Facilities, Florida State Plan, 1969, op. cit.

EXHIBIT 3.13

PROJECTED NUMBER OF NURSING HOME BEDS NEEDED BY COUNTY IN FLORIDA, 1968

	Method of Projecting Beds Needed				
	(1)	(2)	(3)	(4)	(5)
County	Maximum Medical	Minimum Medical	Govern-ment	Other	Average
Alachua	310	167	274	280	173
Baker-Union	53	30	50	48	45
Bay	177	99	205	160	160
Bradford	53	30	77	48	52
Brevard	758	424	458	684	581
Broward	2813	1575	1545	2540	2118
Calhoun	35	20	32	32	30
Charlotte	225	126	114	204	167

(1) Maximum medical bed needs were estimated on the basis of 44.3 beds needed for every 1,000 persons sixty-five and over. This rate was obtained in a Public Health Service survey on the number of persons receiving care at home. See: U. S. National Health Survey: Persons Receiving Care at Home, United States, July 1958-June 1959. Public Health Service Publication No. 584-B28, Washington, D.C., Department of Health, Education, and Welfare. 1961.

(2) Minimum medical beds needed were estimated on the basis of 24.8 beds needed for every 1,000 persons sixty-five and over. This rate was obtained from the Public Health Service survey on the number of persons receiving constant or full-time care at home. See: U. S. National Health Survey.

(3) The government projections were obtained from estimates made for Hill-Burton program by the State of Florida and published in the Florida State Plan.

(4) The other projections were based on rule of thumb estimates used by investment studies. The rate used was 40 beds per 1,000 persons age sixty-five and over. See footnote 35 of this chapter.

(5) The average estimate was mean average of the first four estimates.

EXHIBIT 3.13 (Continued)

County	Method of Projecting Beds Needed				
	Maximum Medical	Minimum Medical	Govern-ment	Other	Average
Citrus	115	64	63	104	87
Clay	128	72	86	116	100
Collier	133	74	112	120	110
Columbia	115	64	88	104	93
Dade	5865	3284	4092	5296	4634
Desota	97	55	63	88	76
Duval	1555	870	1361	1404	1298
Escambia	518	290	494	468	443
Franklin-Liberty	62	35	42	56	49
Gadsden	208	116	138	188	163
Gulf-Hamilton	66	37	68	60	58
Hardee	80	45	52	72	249
Hendry-Glades	49	27	57	44	44
Hernando	97	55	66	88	77
Highlands-Okeechobee	222	124	131	200	169
Hillsborough	2144	1200	1246	1936	1632
Holmes	71	40	61	64	59
Indian River	235	131	114	212	173
Jackson	164	92	119	148	131
Lake	505	283	518	456	441
Lee	518	290	236	468	378
Leon-Wakulla-Jefferson	368	206	312	332	305
Levy-Gilchrist-Dixie	120	67	73	108	92
Madison	75	42	57	68	61
Manatee	882	493	526	796	674
Marion	354	198	224	320	274
Martin	186	104	110	168	142
Monroe	173	97	168	156	149
Nassau-Washington-Okaloosa	267	151	325	244	247
Orange	1431	801	1042	1292	1142
Osceola	244	136	233	220	208
Palm Beach	1905	1066	1297	1720	1497
Pasco	518	290	256	468	383
Pinellas	5391	3021	5207	4868	4622
Polk	1249	699	591	1128	917
Putnam	159	89	112	144	126
St. Johns	182	102	156	164	151
St. Lucie	279	156	179	252	217

Exhibit 3.13 (Continued)

County	Method of Projecting Beds Needed				
	Maximum Medical	Minimum Medical	Govern-ment	Other	Average
Santa Rosa	93	52	115	84	86
Sarasota	886	496	836	800	755
Seminole	297	166	222	268	238
Sumpter	80	45	56	72	63
Suwannee-Lafayette	106	60	78	96	85
Taylor-Walton	133	74	113	120	110
Volusia-Flagler	1621	908	1166	1464	1290
Total	34,377	19,245	25,804	31,040	27,617

use in administering the Hill-Burton program in Florida. The Hill-Burton program is a joint State-Federal program of grants-in-aid for the construction of hospitals and public health facilities.

The Florida State Plan projects nursing home bed needs based on five factors. They are (1) current area resident population estimates, (2) projected five year area resident population estimates, (3) current area use rate of long-term facilities by the existing population, (4) a 90 per cent occupancy factor, and (5) per cent of the population over 65.[34] The projections of bed needs for Florida counties is given in Exhibit 3.13.

[34] Ibid., pp. 37-41.

EXHIBIT 3.14

MARKET DEMAND FOR NURSING HOMES BASED ON NUMBER OF BEDS EXISTING, NUMBER OF BEDS NEEDED, AND ON AVERAGE OCCUPANCY RATES, BY COUNTY FOR FLORIDA

County	(1) Existing Number of Beds 1967	(2) Average Beds Needed	(3) Net Number of Beds Needed	(4) Per Cent of Need Met	(5) Occupancy Rate
Alachua	90	173	83	52%	79%
Baker-Union	0	45	45	0	--
Bay	206	160	(46)	129	68
Bradford	55	52	(3)	115	95
Brevard	211	581	370	36	89
Broward	1135	2118	983	54	82
Calhoun	0	30	30	0	--
Charlotte	0	167	167	0	--
Citrus	0	87	87	0	--
Clay	21	100	79	21	57
Collier	0	110	110	0	--
Columbia	65	93	28	70	65
Dade	3708	4634	926	80	86
Desota	0	76	76	0	--
Duval	1381	1298	(83)	106	88
Escambia	264	443	179	60	88
Franklin-Liberty	0	49	49	0	--
Gadsden	0	163	163	0	--
Gulf-Hamilton	0	58	58	0	--
Hardee	0	249	249	0	--

(1) Source: Annual Report, 1967, Florida State Board of Health, pp. 108-9.

(2) From Column (5) of Table 3.14.

(3) Column (2) minus Column (1).

(4) Column (1) divided by Column (2).

(5) Occupancy rates were calculated by dividing the total possible number of patient days (365 times the bed capacity of the home) into the actual number of patient days for 1967. Source for patient day information: Florida State Plan.

EXHIBIT 3.14 (Continued)

County	Existing Number of Beds 1967	Average Beds Needed	Net Number of Beds Needed	Per Cent of Need Met	Occupancy Rate
Hendry-Glades	0	44	44	0	--
Hernando	37	77	40	48	80
Highlands-Okeechobee	48	169	121	28	94
Hillsborough	1416	1632	216	87	90
Holmes	36	59	23	61	100
Indian River	102	173	71	59	60
Jackson	0	131	131	0	--
Lake	473	441	(32)	107	75
Lee	237	378	141	63	94
Leon-Wakulla-Jefferson	162	305	143	53	90
Levy-Gilchrist-Dixie	75	92	17	81	--
Madison	0	61	61	0	--
Manatee	351	674	323	52	79
Marion	84	274	190	31	60
Martin	60	142	82	42	78
Monroe	9	149	140	6	--
Nassau-Washington-Okaloosa	0	247	247	0	--
Orange	801	1142	341	70	89
Osceola	93	208	115	45	100
Palm Beach	1237	1497	260	83	89
Pasco	112	383	271	29	85
Pinellas	3737	4622	885	81	74
Polk	458	917	459	50	92
Putnam	50	126	76	40	--
St. Johns	161	151	(10)	106	88
St. Lucie	79	217	138	36	89
Santa Rosa	0	86	86	0	--
Sarasota	588	755	167	79	81
Seminole	40	238	198	17	90
Sumpter	25	63	38	40	80
Suwannee-Lafayette	44	85	41	52	100
Taylor-Walton	0	110	110	0	--
Volusia-Flagler	917	1290	373	71	93
Total	18,568	27,617	9,049	67	

In analyzing bed needs, the Florida State Plan sets standards for nursing homes. In their planning, nursing homes are classified as either conforming, needing modernization or not conforming. Of the 18,339 licensed nursing home beds in Florida, the State Plan classifies 14,876 beds, or 81 per cent, as conforming to their standards, 1,261 as non-conforming but able to be modernized, and 2,202 beds as not conforming to standards and not able to be modernized. When analyzing the market demand for nursing homes in conjunction with the supply existing, the status of existing homes needs to be considered. It is anticipated that these homes not conforming to the standards will be phased out of existence by actions of the State Board of Health as being facilities not meeting State requirements.

OTHER PROJECTIONS OF THE NEED FOR NURSING HOMES

Rule of thumb projections for nursing home bed needs have been estimated as being from forty to forty-five beds per one thousand persons past sixty-five.[35] These projections for Florida are given in Exhibit 3.13. In Exhibit 3.13 the

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[35] A. G. Becker & Company, Inc., Basic Report on: The Health Care Industry (New York: A. G. Becker & Company, Inc., 1969), p. 8. Also, Coleman and Company, op. cit., p. 9.

projections were based on the ratio of forty beds per one thousand persons past age sixty-five.

SUPPLY AND DEMAND FOR NURSING HOMES IN FLORIDA

In the previous sections of this chapter, the supply of nursing homes in Florida was examined with respect to size, ownership, and the distribution in the State. The need for nursing home care was examined and projections of need for nursing home care was projected by county by various techniques. For this section, the supply and need information was combined to project the current market conditions of the nursing home industry in Florida.

Exhibit 3.14 gives the existing number of nursing homes by county in Florida. In Column 2 of the Exhibit, the numerical average of the four projections from Exhibit 3.13 is provided. For this analysis, this composite estimate of need was used. Column 3 provides the net difference between the supply available (Column 1) and the need (Column 2) by county, and Column 4 shows the per cent of the need for nursing homes met by the existing supply. Columns 3 and 4 of Exhibit 3.14 summarize the un-met needs for nursing homes of the counties in Florida. Based on this information, Florida needs an additional 9,049 nursing home beds. The current

supply of nursing home beds provides for only 67 per cent of the total beds needed in Florida.

Based on the above analysis alone, the demand for nursing homes in Florida is great and in need of much expansion. These projections, based on various estimates of beds needed, should not be accepted alone at face value. The current conditions in the nursing home field in the various counties should also be examined along with the projected un-met need statistics. Column 5 provides estimates of occupancy rates for Florida counties and indicates the business status of nursing homes in the counties. The higher the occupancy rates, the greater the un-met demand should be. For businessmen deciding on building a nursing home in a county, three statistics are most important. They are the number of nursing home beds needed (Column 3),the per cent of the total beds needed met by the current supply of beds existing in the county (Column 4), and the occupancy rates of the county (Column 5). The right conditions for building a nursing home in a county are a large number of beds needed, a low per cent of need met, and a high occupancy rate.

SUMMARY OF FINDINGS

The aged care industry is composed of four types of facilities--hospitals, nursing homes, homes for the aged, and

home care programs. These institutions differ with respect to the amount of care provided to the aged, with hospitals providing the most and home care programs providing the least. These institutions are part of the "total" approach to care of the aged, whereby an aged person is able to return gradually to normal activities after a major illness. By each institution's specializing in a specific area of the aged care industry, the aged are more effectively and efficiently returned to normal activities.

The nursing home area of the aged care industry was the concern of this dissertation. The nursing home industry was analyzed in this chapter with respect to number, size, and ownership. The industry was characterized as being small institutions that were privately owned. The industry has expanded rapidly in recent years, and most of the nursing home physical plants in Florida are new facilities.

The use of nursing home facilities was examined by delineating the market segment to which nursing homes appeal. The patients in a nursing home are primarily aged sixty-five and over, white, and female. Age is the single most effective factor in delineating the market for nursing homes, and the ratio of the number of nursing home beds per one thousand persons age sixty-five and over is an important statistic in analyzing the nursing home market.

The use of nursing homes was analyzed with respect to the occupancy rates. Occupancy rates were examined with respect to size of the home and ownership of the home. Smaller nursing homes have higher occupancy rates than larger institutions, and non-profit homes have higher occupancy rates than proprietary facilities.

The ability of patients to pay for nursing home services was analyzed with respect to the two major sources of financing--private and public sources. Private sources include both income and the use of assets. Public sources include both Federal financing and state and local financing. Public assistance programs are a joint Federal, state, and local government venture, and Medicare is strictly a Federal operation. With the rapid growth of public sources of financing nursing home care, nursing home care is within reach of practically all persons sixty-five and over.

The need for nursing home care was projected based on several techniques. A composite need estimate was made for each county and compared with the existing supply. In deciding on building a new nursing home, three factors are essential considerations. They are the number of nursing homes needed in a county, the proportion of the need actually met by the existing supply, and the occupancy rates of the existing nursing homes. The relationship of these three

statistics are critical in determining the "actual" need for a nursing home.

CHAPTER IV

MARKET SEGMENTATION IN THE NURSING HOME INDUSTRY

In the previous two chapters, background information on the nursing home industry was presented in order to provide background for analysis of the marketing strategy of nursing homes. In this and the following chapter, an empirical investigation of the marketing strategy of nursing homes is presented. An analysis of market segmentation in the nursing home industry is presented in this chapter. The objective was to test whether nursing homes actually do segment the total market and to analyze the characteristics of various groups of homes. The methodology employed in this analysis is presented in the following section.

METHOD OF ANALYSIS

In order to investigate market segmentation in the nursing home industry, the total market was segmented by the medical needs of patients, and the marketing strategy of nursing homes appealing to these various segments was analyzed. In this section the basis for segmenting the nursing home market is examined, and the method of classifying the

surveyed homes is discussed.

SEGMENTATION BASED ON THE MEDICAL NEEDS OF PATIENTS

There are numerous possible approaches to segmentation of the nursing home market, i.e., age, sex, race, income, geographical factors, or source of patient funds. For the research of this dissertation, one method of segmenting the market was used: segmenting by the medical needs of patients. Segmenting the nursing home market by the medical needs of patients is a most useful and effective approach.[1]

Segmenting by the medical needs of patients relates to the degree and extent of medical care needed by the patients in a nursing home. All individuals in the total nursing home market can be classified on a continuum by the amount of care needed. Some persons need practically constant care by a skilled nurse, while at the other extreme are persons requiring practically no medical care. For this study, three categories of medical care were used. At the top extreme are persons requiring intensive nursing care, and at the other extreme are persons requiring only minimal nursing care. The third category represents those persons

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[1]John B. Sherman, "Categories of Care," Nursing Homes, Vol. 16, No. 12 (December, 1967), pp. 22-24.

falling between the two extremes with regard to the amount of care provided.

There were two primary reasons for the use in this dissertation of segmentation based on the medical needs of patients. The first was that this approach divided the total market into segments that have some relevance to the marketing variables of the firm. Segmentation based upon the medical needs of patients provides the nursing home with the opportunity to design an effective marketing mix for one segment in order to establish a differential advantage for the firm. For example, the services provided by a nursing home are directly related to the medical needs of the patients. Persons needing a large degree of care are practically in need of a small hospital. This type of facility can be specially designed for intensive medical care with a well-trained staff and well-supplied with medical equipment. At the other extreme are persons who desire companionship or just don't care to live alone. These persons are not desirous of living with sick dying people, but seek a nice, reasonable place to live. They don't need skilled nurses or expensive medical facilities.

The second reason for segmenting the market by the medical needs of the patients was that this approach focuses on needs of patients rather than on only descriptive

characteristics of patients. The administrator takes into account the reasons for considering a person a potential customer and what the needs of patients are. If a person needs a nursing home because it offers intensive medical care, then the nursing home can design its marketing strategy around the medical needs of the patient. On the other hand, if a person seeks a nursing home primarily for custodial care rather than medical care, then a different marketing strategy is appropriate. By dividing the market by medical factors, the home defines its market segments based upon how the home can seek to satisfy the needs of the consumers.

METHOD OF CLASSIFYING SURVEYED HOMES

The objective of this research was to analyze the marketing strategy of nursing homes according to the target market the nursing home has selected. For this study, defining the target market in terms of the medical needs of patients was deemed the most effective method. In order to conduct this analysis, ninety-seven Florida nursing homes were surveyed with respect to their marketing policies.[2] The

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[2]Refer to Chapter I, pp. 17-20 for a description of the survey procedures.

characteristics of the patients in these nursing homes were examined in order to identify the target market of each nursing home. These homes were then classified into one of three categories according to their patient composition. The three categories were (1) intensive care homes, (2) limited care homes, and (3) minimal care homes. Intensive care homes had patients requiring a maximum amount of nursing care, and minimal care homes had patients requiring a minimum amount of nursing care. Limited care homes had a combination of types of patients and did not fall into either the intensive or minimal care categories.

The method of classifying the ninety-seven homes which were surveyed was partially subjective. The basis of classifying was the proportion of patients classified as: (1) bedfast, (2) ambulatory, (3) covered by Medicare, and (4) having transferred to the home from a hospital. The relative proportion of patients in these categories was used to classify the ninety-seven nursing homes into groups.

The means of these four statistics for all the nursing homes surveyed were compared with the individual statistics for each home. Homes that had an above average proportion of patients classified as Medicare, bedfast, and transferring from a hospital, and a below average proportion of patients classified as ambulatory, were classified as intensive care

homes. Minimal care homes had a below average proportion of patients classified as Medicare, bedfast, and transferring from a hospital, and an above average proportion of patients classified as ambulatory. The patients in limited care nursing homes had characteristics that did not fit into either of these previous two categories.

Out of ninety-seven nursing homes, four homes were not classified because of insufficient information on the characteristics of their patients. A total of ninety-three homes were used in the analytical part of this dissertation. Twenty-nine homes were classified as intensive care homes, thirty-eight were classified as limited care homes, and twenty-six were classified as minimal care homes.

In the following sections, the three groups of nursing homes were compared with respect to numerous marketing factors. In Chapter V, the three groups of nursing homes were compared with respect to their marketing mix.

COMPARISON OF NURSING HOMES BY CHARACTERISTICS OF PATIENTS

This section compares characteristics of patients in nursing homes which have been classified as intensive, limited, and minimal care homes. The patients in these three categories of homes were compared by demographic

characteristics, medical factors, transference of patients from a hospital, term of patient stay, source of patient referral, and source of patient funds.

DEMOGRAPHIC CHARACTERISTICS OF PATIENTS

The total market for nursing homes was defined in Chapter III in terms of persons aged sixty-five and over. For the nursing homes surveyed, approximately three per cent of the patients were classified as under age sixty-five. All three categories of nursing homes had approximately the same percentage of patients under age sixty-five. Based on these estimates, age is of little significance in analyzing the marketing strategy of nursing homes.

With respect to race and sex, there were no significant differences among the three categories of homes. An estimated sixty-nine per cent of patients in the surveyed homes were female and thirty-one per cent were male. The average proportion of non-white patients in all three categories of homes was slightly less than five per cent.

MEDICAL CONDITION OF PATIENTS

Two statistics were used in order to characterize the medical condition of nursing home patients. The proportion of patients categorized as bedfast versus the proportion categorized as ambulatory was one method of projecting the

degree of medical care required by patients in nursing homes. Patients confined to bed are in need of greater medical care than patients that are ambulatory. Exhibit 4.1 provides these statistics on the patients in the surveyed nursing homes.

EXHIBIT 4.1

COMPARISON OF PATIENTS IN NURSING HOMES BY MEDICAL CONDITION: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Medical Classification of patients				
Bedfast	42%	36%	24%	35%
Ambulatory	34	47	55	45
Other	24	17	21	20
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

In Exhibit 4.1, nursing home patients were divided into one of three categories of care. At one extreme are patients confined to bed and at the other extreme are those patients classified as ambulatory. The "other" category consists of patients that do not fall into either the bedfast or ambulatory category and consists of patients such as those confined to wheel chairs. For all the surveyed homes, only

a third of the patients were confined to bed. Unlike a hospital, a nursing home has a majority of their patients able to get about and move around.

These statistics on the proportion of patients in a home classified as bedfast and as ambulatory were used to categorize the surveyed homes into one of the three groups. There exists a direct relationship between the category of home and classification of patients. As can be seen from Exhibit 4.1, intensive care homes had a higher proportion of bedfast patients than did minimal care homes. With respect to the proportion of ambulatory patients in the homes, minimal care homes had a substantially higher proportion of these patients than did intensive care homes. These relationships were anticipated since intensive care homes were defined in terms of patients needing intensive medical care, which includes a high proportion of bedfast patients and a low proportion of ambulatory patients. A reverse relationship exists for minimal care homes, which were defined in terms of patients needing only a minimal amount of medical care.

TRANSFERENCE OF PATIENTS FROM A HOSPITAL

As shown in Exhibit 4.2, the majority of nursing home patients transfer to a home directly from a hospital. Patients entering a home directly from a hospital are in need

of greater medical care than patients entering a nursing home from another source. Patients are in a hospital specifically to receive medical care, and they transfer to a nursing home to receive a continuation of medical care. Persons not in a hospital generally are not in need of as much care as persons in a hospital.

EXHIBIT 4.2

COMPARISON OF NURSING HOMES BY PROPORTION OF PATIENTS TRANSFERRING FROM A HOSPITAL: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Source from which patient transferred to nursing home				
Hospital	84%	67%	19%	59%
Other Source	16	33	81	41
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

These statistics on the proportion of a nursing home's patients entering directly from a hospital were used to classify the surveyed homes into groups. As can be seen from Exhibit 4.2, a large majority of patients in intensive care homes come from a hospital to the nursing home, whereas

with minimal care homes only a small percentage of their patients enter the nursing home from a hospital. This relationship exists because these statistics were an indicator of the degree of medical care needed by patients.

TERM OF PATIENT STAY

Exhibit 4.3 summarizes the proportion of patients in nursing homes by their length of stay. Patients remaining in a nursing home for years consider the nursing home as an actual home, which is different from the view taken by short-term patients. Short-term patients are in a nursing home for a particular reason, such as recovering from an operation, and they consider the nursing home as a temporary residence. The needs of these two categories of patients are different and must be taken into consideration when designing a home's marketing strategy. As can be seen from Exhibit 4.3, the majority of nursing home patients are in a nursing home for a long stay. Traditionally, nursing homes have been institutions providing primarily long-term care, a ough short-term patients are an important segment of the market to many homes.

Intensive care homes have a high proportion of short-term patients and a low proportion of long-term patients. On the other hand, minimal care homes have a high proportion of long-term patients and a low proportion of short-term patients.

Based on these statistics, as shown in Exhibit 4.3, patients needing intensive medical care are generally short-term patients, and patients needing a minimal degree of care are long-term patients.

EXHIBIT 4.3

COMPARISON OF PATIENTS IN NURSING HOMES BY TERM OF STAY: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Length of patient's stay				
Long-term	38%	73%	92%	67%
Short-term	51	25	6	28
Other	11	2	2	5
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

Intensive care homes are more expensive than the other groups of homes since they provide more in the line of costly medical services. Long-term patients are generally not in need of intensive care and do not want to pay for such care. Limited and minimal care homes provide the services and facilities that long-term patients need and can afford.

SOURCE OF PATIENT REFERRAL

Patients generally enter a particular nursing home on reference from some particular source such as a relative, friend, or doctor. As shown in Exhibit 4.4, doctors are the single most important source for referral of patients among the surveyed homes. Nursing homes specialize in providing medical care to the elderly, and doctors are the logical expert for a person to consult regarding which nursing home to select. Doctors play an important role as an intermediary between the patient and the nursing home, and the marketing strategy of nursing homes needs to be designed with the physician in mind.

The doctor is not the primary source of patient referral for all nursing homes. As shown in Exhibit 4.4, friends and relatives are the single most important source of referral for minimal care homes. The physician plays a less crucial role as an intermediary for minimal care homes since less than a third of the patients in minimal care homes are referred by a doctor. Minimal care homes were defined as homes providing minimal care to patients, and it is logical that the physician does not play so active a role in the firm's total competitive effort.

EXHIBIT 4.4

COMPARISON OF NURSING HOMES BY SOURCE OF PATIENT REFERRAL: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Source of patient referral				
Doctors	56%	46%	31%	45%
Hospital	17	16	6	13
Church	5	4	5	5
Friends & Relatives	15	30	41	28
Other	7	4	17	9
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

SOURCE OF PATIENT FUNDS

The three sources of funds to pay for patients' care in a nursing home are Medicare, welfare--both state and local, and private sources. Medicare covers short-term care, less than 100 days, for persons in need of skilled nursing care.[3] Welfare covers that care for indigents not covered

[3]Pierre Salmon, "The Medical Implications of Medicare," Nursing Homes, Vol. 15, No. 7 (July, 1966), pp. 13-17.

by Medicare, which is primarily long-term care for persons not in need of "skilled nursing care." As shown in Exhibit 4.5, slightly over one half of the patients in nursing homes receive public funds (Medicare or welfare) for their care. The relative role of the two sources of public funds varies among the surveyed homes.

EXHIBIT 4.5

COMPARISON OF PATIENTS IN NURSING HOMES BY SOURCE OF PATIENT FUNDS: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Source of patient funds				
Medicare	52%	22%	2%	26%
Welfare	6	26	48	26
Private	42	52	50	48
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

Intensive care nursing homes provide the "skilled care" needed by Medicare patients, but not needed and too expensive for welfare patients. For a person to be covered by Medicare while in a nursing home, this person must need "skilled

nursing care."[4] This limits Medicare patients to those persons in need of intensive medical care, and as shown in Exhibit 4.5, the intensive care homes had a substantially higher proportion of patients classified as Medicare patients. The fact that a nursing home has few Medicare patients does not automatically mean that the home is a minimal care nursing home, since some homes do not accept Medicare patients for other reasons.[5]

Minimal care homes do not provide the "skilled care" needed by Medicare patients, but do provide the minimal care needed by many welfare patients. Limited care homes have a fair proportion of welfare patients who are probably those welfare recipients in need of care greater than that provided by minimal care homes. All nursing homes have a representative proportion of private patients. Intensive care homes have a slightly lower proportion of private patients than the other groups of nursing homes partially because they are generally higher priced facilities, and private patients are more price conscious than Medicare patients.

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[4] Ibid.

[5] One Florida nursing home, for example, refused to accept Medicare patients in order to avoid becoming involved in Federal "red tape" and to restrict the type of patients entering the nursing home.

COMPARISON OF NURSING HOMES BY SIZE AND OWNERSHIP

In the following two sections, the average size of the three categories of nursing homes is compared. A second comparison of the three categories of homes is provided on the ownership of these nursing homes.

SIZE OF NURSING HOMES

Comparison of the three categories of nursing homes by their number of beds shows that the greater the medical care needed by patients, the larger the nursing home. As shown in Exhibit 4.6, intensive care homes were on the average larger than both limited and minimal care homes. Fifty-four per cent of minimal care homes had fifty beds or less, whereas only fourteen per cent of intensive care homes had fifty or less beds.

EXHIBIT 4.6

COMPARISON OF NURSING HOMES BY NUMBER OF BEDS: AUGUST, 1968

Nursing Home Category	Average Size (number of beds)
Intensive Care	94.2
Limited Care	75.8
Minimal Care	63.7
All Homes	78.2

Source: Mail Survey of Florida Nursing Home Administrator

A major reason for this relationship between size and the three categories of nursing homes is the economies of scale available in providing medical care to nursing home patients. In order to provide a wide range of medical care services efficiently, a large number of patients are needed. Skilled nursing care is expensive, and so is the variety of medical equipment needed by intensive care patients. The high fixed costs needed to provide these facilities and staff do not vary substantially by the size of nursing homes. For example, a fifty bed nursing home needs five nurses per day while a one hundred bed home needs only seven nurses.[6] For a home double in size (one hundred beds), the home only needs forty per cent more nurses than the fifty bed home. Assuming an average cost per eight hour day for a nurse of $25, the average nursing expense per day is $2.50 in a fifty bed home and $1.75 in a one hundred bed home. The above example is just one illustration of how economies of scale are effective in providing medical care to patients in a nursing home.

OWNERSHIP OF NURSING HOMES

As shown in Exhibit 4.7, the majority of the surveyed

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[6]Florida State Board of Health, Rules of the Florida State Board of Health Facilities, Chapter 170D-2, Jacksonville, Florida, Revised March, 1964, p. 205.

homes are proprietary institutions. Non-profit homes include government, religious, and fraternal homes. Non-profit homes are primarily either intensive or minimal care facilities rather than the middle category of limited care homes. Although the sample of non-profit homes is small (twelve homes),[7] this relationship does imply that non-profit homes put more emphasis on specializing in one market segment than do proprietary nursing homes. Only two of the twelve non-profit nursing homes do not specialize on either the minimal care segment or the intensive care segment of the market. Based on these statistics, non-profit homes appear to place more emphasis on segmenting the market and selecting a target market than do proprietary nursing homes.

EXHIBIT 4.7

COMPARISON OF FLORIDA NURSING HOMES
BY OWNERSHIP: AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of nursing homes)			
Ownership of homes				
Proprietary	83%	95%	81%	87%
Non-profit	17	5	19	13
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators

[7]The Florida State Board of Health classified 83 per

COMPARISON OF HOMES BY MARKET AREA FACTORS

In the following two sections, market area factors relating to the three categories of nursing homes are compared. The size of the area from which a nursing home attracts its patients is examined and the population characteristics of the market areas are compared.

POPULATION OF MARKET AREAS OF NURSING HOMES

By defining the market area of a nursing home as the county boundaries, Exhibit 4.8 summarizes the population of the counties of the three categories of nursing homes.[8] The majority of the surveyed homes are located in large metropolitan areas. Several large cities in Florida (St. Petersburg, for example), have an above average proportion of elderly people attracted from the North. This concentration of the transplanted aged from the North to certain Florida cities helps bring a concentration of nursing homes in these cities. The type of nursing homes located in the

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cent of all Florida nursing homes as proprietary and 17 per cent as non-profit homes. See: Florida State Board of Health, Florida State Board of Health Annual Report, 1967, Jacksonville, Florida, 1968, p. 111.

[8]Refer to Chapter III, p. 62 for an analysis of the market area for nursing homes.

larger metropolitan areas differs from the homes located in the smaller counties.

EXHIBIT 4.8

COMPARISON OF FLORIDA NURSING HOMES BY POPULATION OF THE MARKET AREA, AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of nursing homes)			
County Population*				
Less than 100,000	28%	21%	31%	26%
100,000 to 299,999	10	29	15	19
300,000 to 499,999	52	39	42	44
500,000 and over	10	11	12	11
Total	100%	100%	100%	100%

*County population figures based on 1967 estimates. University of Florida, Bureau of Economic and Business Research, Florida Statistical Abstract, 1968, (Gainesville, Florida: University of Florida, 1968), pp. 27-29.

Source: Mail Survey of Florida Nursing Home Administrators.

Specialized facilities providing either intensive or minimal care are located more frequently in larger metropolitan areas than are limited care homes which do not specialize with regard to the type of care they provide. Fifty

per cent of limited care facilities are located in counties with less than 300,000 population, whereas only thirty-eight per cent of intensive care homes and forty-six per cent of minimal care homes are located in counties with less than 300,000 population. Limited care homes are "general store" operations since they provide all types of care, whereas intensive and minimal care homes specialize in the care they provide. Specialists are in greater demand in larger population areas than are generalists, so that limited care homes are more appropriately suited for smaller population areas.

COMPARISON OF NURSING HOMES BY SIZE OF MARKET AREA

The market area served by a nursing home, defined in terms of the area from which a home draws its patients, is primarily local. As shown in Exhibit 4.9, approximately eighty-seven per cent of the patients in nursing homes live within twenty-five miles of the nursing home prior to entering the home.

Intensive care homes drew slightly more patients from within a twenty-five mile radius of their homes than did limited and minimal care homes. This factor is partially explained by the larger proportion of intensive care homes in the large metropolitan areas. The larger the city where

the nursing home is located, the less the need to attract patients from farther distances.

EXHIBIT 4.9

COMPARISON OF FLORIDA NURSING HOMES BY DISTANCE OF PATIENTS' RESIDENCE PRIOR TO ENTERING NURSING HOME, AUGUST, 1968

	Nursing Home Category			
	Intensive Care	Limited Care	Minimal Care	All Homes
	(per cent of patients)			
Distance of patients' residence prior to entering nursing home				
Less than 10 miles	52%	58%	56%	56%
10 to 25 miles	38	27	26	30
Greater than 25 miles	10	13	16	13
Total	100%	100%	100%	100%

Source: Mail Survey of Florida Nursing Home Administrators.

COMPARISON OF NURSING HOMES BY SEASONAL VARIATION

Many industries in Florida are directly affected by the seasonal variation in the population of the State. The majority of nursing homes surveyed do not experience seasonal variation in their business. Limited care homes reported the least amount of seasonal variation with eighty-one per cent

of these homes reporting no seasonal variation. Fifty-nine per cent of intensive care homes and fifty-three per cent of minimal care homes reported having no seasonal variation. Two factors help account for the smaller amount of seasonal variation experienced by limited care homes. First, limited care homes are primarily in the smaller metropolitan areas where tourists are not as numerous, and second, limited care homes have a large proportion of long-term patients who stay year-round. Intensive care homes attract a large proportion of short-term patients and experience more seasonal variation. Minimal care homes experience a seasonal variation from tourists who are able to return to the North for the summer months and spend the winters in Florida.

The peak winter months, January to March, were reported as being above average with respect to occupancy. The period from July to September was below average, while the other months were considered normal. This type of seasonal variation coincides with the typical tourist cycle when the winter season has the heavy influx of tourists and the summer season has the low number of tourists.

SUMMARY OF FINDINGS

A most effective and practical method of dividing the nursing home market is by the amount of nursing care needed

by patients. This method of segmentation was used to divide the Florida nursing home market into three segments: intensive care, limited care, and minimal care patients. The nursing homes in Florida were surveyed and divided into one of three categories depending on the market segment by which their patients were classified.

The objective was to analyze the marketing strategy of these three segments. This chapter examined selected characteristics of these three categories of nursing homes and compared the three categories for significant differences. Since the characteristics of the patients in the three categories of nursing homes were used as the basis of classifying the nursing homes, there was a direct relationship between the three categories of homes and the characteristics of their respective patients. That is, the number of bedfast patients in a home was one fact used to categorize nursing homes, and intensive care homes naturally had a larger proportion of bedfast patients than did minimal care homes. Other comparisons showed that intensive care homes had a relatively small proportion of ambulatory, welfare, and long-term patients and a relatively large proportion of Medicare, bedfast, and short-term patients. Minimal care homes on the other hand had relatively few Medicare, bedfast, and short-term patients, and a relatively large proportion of

ambulatory, welfare, and long-term patients. Limited care homes had a medium distribution of all types of patients.

With regard to size, the greater the medical care needed by patients, the larger the average size of the nursing home. Intensive care homes were larger than limited care homes, which were larger than minimal care homes. With regard to ownership, non-profit homes specialize more than do proprietary homes, which have a large proportion of homes classified as limited care facilities.

A larger proportion of limited care homes are located in smaller population centers than are intensive and minimal care homes. Minimal and intensive care homes are specialists as compared to limited care homes and are in greater demand in metropolitan areas.

Since limited care homes are located in smaller population centers, they attract a larger proportion of their patients from over twenty-five miles from their homes than do intensive and minimal care homes. The larger the metropolitan area, the greater the concentration of people and the less the need to attract patients from farther distances from the nursing home.

Even though Florida has a large proportion of tourists, most nursing homes do not experience a seasonal variation in their business. Of the homes that do experience a seasonal

variation, limited care homes experienced the least amount. Intensive care homes had a large proportion of short-term patients which helps explain the seasonal variation they experience. Minimal care homes have patients who are able to leave the nursing home for the summer to return north. These patients do not need the degree of medical care that requires them to remain in a nursing home.

The three categories of nursing homes discussed in this chapter exhibit numerous differences. Many nursing homes apparently do segment the market and appeal to one segment or another. In the following chapter, the marketing strategies of these three segments are analyzed.

CHAPTER V

THE MARKETING MIX OF FLORIDA NURSING HOMES

In Chapter IV, three market segments for nursing homes were identified based upon the medical needs of nursing home patients, and the surveyed nursing homes were categorized based upon the segment in which the home specialized. In this chapter, the marketing strategy pursued by nursing homes toward these three segments was analyzed. The objective was to test hypotheses concerning the role of various components of the marketing mix for the three categories of homes.

METHOD OF ANALYSIS

The marketing mix of nursing homes was analyzed by two basic approaches. The first, more general approach, consisted of analyzing the relative importance given by administrators to six basic components of the marketing mix. The surveyed administrators rated the importance of price, location, advertising, physical facilities, services provided, and quality of nursing care, regarding their part in attracting patients to a nursing home. The relative importance given these six factors in the marketing mix was compared for

the three categories of homes.

The second, more specific approach, involved an analysis of specific aspects of the components of the marketing mix. The marketing mix for nursing homes was divided into four major components and numerous sub-components. All components of the marketing mix of nursing homes fall into one of these categories: product, location, price or promotion. The first major category was the product mix of nursing homes, and this category was divided into three sub-components: medical care, personal services, and facilities. Nursing home administrators were surveyed with regard to what services and facilities the nursing homes provide for their patients. The various services and facilities provided by the three categories of nursing homes were compared in order to test for differences in the product mix of the three categories of homes.

In order to analyze the role of location of a nursing home in the firm's marketing mix, administrators rated the relative importance of several factors that influence the location of a nursing home. The objective was to determine the relative importance of factors that intensive, limited, and minimal care homes considered in the location of a nursing home.

The pricing policies of nursing homes were divided into two areas for purposes of analysis. First, the basic room charges were compared for the three categories of nursing homes. Second, the pricing policies of nursing homes regarding special services and facilities were examined. The objective was to test how inclusive were the basic room charges for the three categories of nursing homes.

Promotion policies of nursing homes were difficult to analyze by use of a mail questionnaire and, for this reason, the analysis was limited in scope. The only analysis conducted concerning promotion policies was on the relative importance of various advertising media.

In the following section, the first, general approach to analyzing the marketing mix is provided. The sections following this analysis concern the second, detailed approach.

IMPORTANCE OF THE COMPONENTS OF THE MARKETING MIX

The administrators of the surveyed nursing homes rated the importance of six factors in attracting patients to their homes. These factors represented six major components of the marketing mix of nursing homes. The six factors were price, location, advertising, physical facilities, services

provided, and quality of nursing care.

The administrators classified each of the factors into one of five degrees of importance: unimportant, below average, average, above average, and very important. An "importance rating" for the six factors was calculated by giving each rating of importance a value from one to five such that the more important the factor, the higher the rating. Factors classified as unimportant received a value of one, and at the other extreme, factors rated very important were given a score of five. The mean score of the ratings for all nursing homes was calculated, and this value is referred to as the "importance rating." An "importance rating" was calculated for each component such that the higher the value, with five being the highest, the more important was the factor in attracting patients.

COMPONENTS OF THE MARKETING MIX

Two significant observations are ascertained from the analysis of the "importance ratings" given in Exhibit 5.1. First, the six factors rated by the administrators were not all considered equally important. For example, nursing care was rated far more important than price in attracting patients to a nursing home. Second, three categories of homes rated each factor with varying degrees of importance. For

example, minimal care homes considered price more important than did intensive care homes.

EXHIBIT 5.1

"IMPORTANCE RATING"* OF COMPONENTS OF THE MARKETING MIX

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Factors Attracting Patients to a Nursing Home	(Importance Rating)			
Nursing care	4.78	4.86	4.78	4.65
Physical facilities	4.30	4.50	4.47	3.83
Services	4.11	4.29	4.08	3.84
Location	3.74	3.70	3.78	3.64
Price	3.29	2.78	3.37	3.77
Advertising	1.93	1.92	2.00	1.67

*The "Importance Rating" is the mean score of importance given the factor by the surveyed administrators. The higher the value, with five being the maximum, the more important is the factor in the marketing mix of nursing homes.

Source: Mail Survey of Florida Nursing Home Administrators.

With respect to the first significant observation, the relative importance of these six factors provides insight into the nature of the marketing mix of nursing homes. The three factors rated most important, nursing care, physical

condition, and services provided, are all part of the product mix of nursing homes. The combination of services and facilities, the product mix, comprise the major segment of the total marketing mix.

The factor rated least important of the six factors and considered unimportant was advertising. Two factors help explain this low rating given advertising. First, the medical care field in general does little advertising. Many professional organizations, such as those of physicians, prohibit advertising among its members. Many other health-related facilities, such as hospitals, do not advertise since they are public agencies operating on a non-profit, quasi-monopoly basis. These two situations help create a general feeling in the medical care field that advertising is not essential.

Second, the minor role of advertising is further explained by the fact that frequently nursing homes are operating in a sellers' market.[1] Demand is greater than available supply in many market areas, thus giving some administrators

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[1]For a discussion on the market supply and demand situation of Florida nursing homes, see Chapter III.

a feeling that advertising is unnecessary. As long as a nursing home has sufficient customers, advertising is frequently considered not necessary.

The second significant relationship observed from the data presented in Exhibit 5.1 was the relative importance given the six factors by the three categories of nursing homes. The quality of nursing care provided by a home was rated as the number one factor of the six factors, but the three categories of nursing homes rated this component of the marketing mix with varying degrees of importance. The relative ratings are consistent with the nature of the needs of the target market of the three groups of homes.[2]

The patients in intensive care homes are in greater need of medical care than are the patients in limited or minimal care homes. For this reason, the role of nursing care is of more importance to intensive care homes than other nursing homes. Minimal care homes, on the other hand, have patients requiring a minimum amount of nursing care. The administrators of these homes considered the role of the nursing care provided as important, but not as important as administrators of intensive or limited care homes.

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[2]For a discussion of the types of patients in the three categories of nursing homes, see Chapter IV.

The other two components of the product mix, physical facilities and services provided patients, received relative ratings similar to the ratings given the quality of the nursing care. Again, these relative ratings were consistent with the needs of the target market. With respect to the physical facilities of the home, minimal care homes have a poorer quality physical plant than the other categories of homes. Minimal care homes are frequently located in older buildings that were converted into nursing homes.[3] These facilities do not meet the standards needed to care for patients requiring intensive medical care and therefore seek only minimal care patients.

With respect to the services available to patients, the patients in intensive care homes are in need of more services than patients in other homes because of their medical needs. For this reason, administrators of intensive care homes considered the services available more important than both of the other two categories of homes.

In addition to the three components of the product mix, the only other factor in which the relative weights given the

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[3]Refer to Chapter II, pp.25-29 for a description on the historical development of nursing homes.

six factors by the three groups of homes varied, was the price charged by the home. Price was the only factor in which minimal care homes gave a higher importance rating than the other categories of homes. These ratings given to price factors in attracting patients to the nursing homes is affected by the price charged to patients. Minimal care homes are less expensive than the other homes.[4] Since the other homes provide more services and have better physical plants, minimal care homes have lower costs and charge lower rates. The role of price is further examined in the section on pricing policies later in this chapter.

SUMMARY OF FACTS

The conclusion reached from analysis of the data presented in Exhibit 5.1 is that the marketing mix of nursing homes varies according to the needs of the nursing home's target market. The patients in intensive care homes need more care, facilities, and services than the patients in the other homes. Intensive care homes consider these product

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[4]The average per diem charge in intensive care homes was $16.62, limited care homes was $14.48, and in minimal care homes was $11.67. For a further discussion on pricing of nursing home services, refer to Chapter V, pp. 155-160.

factors more important than the other categories of nursing homes. Since intensive care homes emphasize their product mix, the other components of the marketing mix are de-emphasized. For minimal care homes, since the product mix is not as crucial as with the other homes, minimal care homes place more relative importance on other factors, such as price. Limited care homes appeal to a broader target market than the other two categories of homes and for this reason have a more general type of marketing mix that falls between intensive and minimal care homes.

THE PRODUCT MIX OF NURSING HOMES

Nursing homes market a service rather than a tangible product. The term product in this dissertation means all the services and facilities the nursing home provides to its customers. This includes nursing care, room, board, and any other services provided. The total combination of services and facilities provided to patients comprise a nursing home's product mix. There are basically three sub-mixes within the total product mix: medical care mix, including both the nursing care provided and the medical services available; the physical facilities mix; and the personal services mix. The following three sections provide an analysis of the product mix of the surveyed nursing homes.

MEDICAL CARE MIX

The primary function of nursing homes is to provide medical care to persons in need of such care. The medical care provided by a home varies by both the degree and the extent of care provided. The extent of care provided involves how many medical services are provided as part of the total medical care mix. The degree of medical care provided involves how well and completely a particular service is provided.

Florida nursing home administrators were surveyed with respect to selected medical services provided by their homes. Exhibit 5.2 summarizes the proportion of nursing homes providing physical therapy, laboratory, occupational therapy, and X-ray services to their patients. The majority of nursing homes in all three categories provide each of these services, though all three groups of homes are not equally likely to provide each medical service. The significance of this data lies in the per cent of each nursing home category providing a service in relationship to the other categories of homes.

The data presented in Exhibit 5.2 supports the primary hypothesis of this dissertation, that nursing homes design a marketing mix around the needs of their target market. With all four medical services, intensive care homes

were more likely to provide the services than limited care homes, which were more likely to provide the services than minimal care homes. This relationship between the three categories of homes is consistent with the needs of the patients in the three groups of homes.[5] Patients in intensive care homes require more medical services than other patients and intensive care homes provide more medical services than the other nursing homes. Patients in minimal care homes require only a minimum amount of medical care, and these homes are less likely to provide all the services that the other nursing homes provide.

EXHIBIT 5.2

FLORIDA NURSING HOMES PROVIDING SELECTED MEDICAL SERVICES, AUGUST, 1968

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Medical Service	(Per Cent of Homes Providing Service)			
Physical Therapy	83%	100%	87%	60%
Laboratory Service	68	89	72	64
X-Ray	60	86	57	58
Occupational Therapy	78	82	82	68
Average Per Cent of Homes	72	89	74	62

Source: Mail Survey of Florida Nursing Home Administrators.

[5]Refer to Chapter IV, p. 109 for a comparison of nursing homes by characteristics of patients.

PERSONAL SERVICES MIX

In addition to providing for the medical care of patients, many nursing homes seek to provide patients with personal services, such as entertainment or a beauty shop. Exhibit 5.3 summarizes the proportion of nursing homes providing four particular personal services. The majority of the nursing homes surveyed provided each of these four services, although there were differences between the various categories of homes, in the proportion of services provided.

EXHIBIT 5.3

PERSONAL SERVICES PROVIDED BY FLORIDA NURSING HOMES, AUGUST, 1968

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Personal Services	(Per Cent of Homes Providing Service)			
Beauty-Barber Shop	91%	97%	94%	83%
Church Services	96	97	95	100
Movies	56	62	81	48
Organized Activities Program	85	90	95	68
Average Per Cent of Homes	82	86	91	75

Source: Mail Survey of Florida Nursing Home Administrators.

The data presented in Exhibit 5.3 support the hypotheses stated in Chapter I. That is, the proportion of each category of nursing homes providing these personal services is consistent with the needs of the respective target markets. Patients in limited care homes fall into the middle category of degree of medical care needed. These patients need more care than patients in minimal care homes, who are generally able to care for themselves, including leaving the nursing home to go to the beauty shop or to the movies. The patients in limited care homes need less care than patients in intensive care homes, who generally are so ill as not to need the services of a beautician or an activities program. Therefore, patients in intensive care homes are less likely to need the personal services than the patients in the limited care homes. Since the patients in minimal care homes are able to secure these personal services outside the nursing home, limited care patients lie between the two extremes of intensive and minimal care. They need the personal services but generally are not able to secure these services on their own. Thus, limited care homes are more likely to provide the personal services than are the other nursing homes.

PHYSICAL FACILITIES MIX

In addition to the personal services provided for patients, numerous physical facilities are provided by nursing homes for the comfort of patients. Exhibit 5.4 shows the proportion of nursing homes having four particular facilities.

EXHIBIT 5.4

PHYSICAL FACILITIES PROVIDED BY FLORIDA NURSING HOMES, AUGUST, 1968

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Physical Facilities	(Per Cent of Homes Providing Service)			
Air Conditioning	89%	97%	92%	52%
Room Phones	50	48	55	31
Library	77	72	86	71
Carpeting	30	31	23	8
Average Per cent of Homes	61	62	64	40

Source: Mail Survey of Florida Nursing Home Administrators.

As can be seen from Exhibit 5.4, there is a significant difference between the facilities provided by minimal care homes and the other two categories of nursing homes. The main conclusion reached is that minimal care homes do not

have facilities as complete or up-to-date as the other nursing homes.[6] Since minimal care homes do not have excellent facilities, these homes do not emphasize this factor in their total marketing strategy, as can be seen from Exhibit 5.1.

Of the four services surveyed, intensive and limited care homes are equally likely to provide a particular facility, whereas minimal care homes are less likely to have these facilities. This relationship between the facilities provided and the three categories of homes is explained by three factors. First, minimal care homes are generally older homes that often are located in converted buildings and are not able to qualify to care for patients requiring more intensive care. These four facilities are generally of the types that require installation at the time of construction of the home. For this reason, minimal care homes are less likely to be able to design these facilities into their homes.

A second factor affecting the low proportion of minimal care homes providing these facilities is the cost involved.

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[6]Refer to Chapter II, pp. 25-29 for a description on the historical development of nursing homes.

These four surveyed facilities are not necessities but are luxury facilities, which are costly to provide. Minimal care homes are the least expensive of the three categories, and therefore they have less revenue available to provide for luxuries.

A third factor affecting the above relationship is the needs of the patients. Patients in intensive and limited care homes are generally confined to the nursing home and, very likely, to their room. For this reason, these patients desire surroundings and facilities that provide the maximum comfort and enjoyment. Patients in minimal care homes are able to leave the premises of the nursing home and are not confined to one building or room. These patients do not need the special facilities as much as do patients in the other categories of homes.

SUMMARY OF FACTS

In the previous three sections, the product mix of the three categories of nursing homes was analyzed for the three categories based upon the proportion of surveyed homes providing various services or facilities. The conclusion reached from this analysis of the product mix was that nursing home administrators do design their product mix around the needs of their respective target markets. Patients in intensive care homes required a maximum amount of medical

care, and these homes provided medical services more frequently than the other nursing homes. Because of their medical conditions, these patients were less likely to need various personal services than patients in better health. The facilities provided to these patients are the finest possible since these patients are confined to one building or room and pay a price sufficient to include excellent facilities.

Patients in limited care homes do not need as much medical care as intensive care patients, and these homes do not provide as much in the line of medical services to their patients. Yet these patients are not of such health as to be able to leave the nursing home at will, so these limited care homes provide personal services and facilities in order to make the patients' stay in the home enjoyable.

Minimal care homes, on the other hand, have patients who are able to care for themselves. These homes do not provide much in the line of medical and personal services to the patients, and the facilities provided are not luxurious in nature. Minimal care patients are able to leave the nursing home and are able to secure personal services on their own and to enjoy other surroundings.

LOCATION OF A NURSING HOME

Many factors affect the choice of a location for a nursing home within a particular community. Among the factors that need to be considered are the needs of the patients, physical characteristics of the site, and the relationship of the nursing home to the medical profession. In order to analyze the importance of various factors in selecting a nursing home site, the surveyed nursing home administrators estimated the relative importance of various factors.

FACTORS RELATING TO LOCATION OF A NURSING HOME

The administrators classified the various factors listed in Exhibit 5.5 by their degree of importance in selecting a site for a nursing home. An "importance rating," similar to that rating calculated in the previous section, was calculated such that each site factor received a rating from one to five. The higher the rating, the more important was the factor in selecting a site. The importance ratings for the surveyed nursing homes are given in Exhibit 5.5.

EXHIBIT 5.5

"IMPORTANCE RATING"* OF FACTORS RELATING TO LOCATION OF A NURSING HOME

	Category of nursing home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Site Factors	("Importance Rating")			
Convenience for doctors	4.53	4.71	4.61	4.35
Closeness to hospital	4.33	4.71	4.35	3.96
Accessibility of land	4.01	4.29	4.05	3.74
Attractiveness of land	3.89	4.21	3.79	3.83
Price	3.40	3.48	3.31	3.61
Closeness to patient's home	2.72	2.82	2.70	2.52
Closeness to business center	2.52	2.39	2.38	2.91

*The "Importance Rating" is the mean score of importance given to the factor by the surveyed administrators. The higher the value, with five being the maximum, the more important is the factor in selecting a site for a nursing home.

Source: Mail Survey of Florida Nursing Home Administrators.

Two significant relationships are discerned from the data presented in Exhibit 5.5. First, all seven factors were not considered equally important in selecting a site for a nursing home. For example, convenience of the site

to doctors was more important than closeness of the site to patient's home. The second significant relationship was that the three categories of nursing homes differed with respect to their ratings for each factor. For example, closeness of the site to a hospital was considered more important to intensive care homes than to minimal care homes. The following paragraphs of this section analyze in greater detail these two relationships.

With respect to the first relationship concerning the relative importance of the seven factors for all the surveyed homes, two significant observations are seen. First, the two primary factors in selecting a site are medical factors: convenience of the site for doctors and closeness of the site to a hospital. Nursing homes are medical institutions, and for this reason, administrators considered the medical implications of a site foremost. As can be seen from Exhibit 5.1, medical factors were the number one factor in attracting patients to a nursing home, and the surveyed administrators were consistent in rating medical factors of primary importance in selecting a site.

The second significant observation on the relative importance of the seven factors is the low ratings given price of a site and the closeness of the site to a patient's home. With respect to the price of a site, the surveyed

administrators considered this factor secondary to the first four factors. The conclusion here is that administrators are conscious of the significance of the site of a nursing home in their total competitive effort.

The low rating given closeness of a site to a patient's home was difficult to analyze. The aged, the primary market for nursing homes, tend to live near each other. This pattern of living is especially common in Florida where many housing areas are exclusively for the elderly.[7] When the aged tend to live close to each other, this area is ripe for the location of a nursing home. Apparently, nursing home administrators do not agree with this analysis since the surveyed administrators rated closeness of a site to a patient's home as sixth in importance out of seven factors.

The second major relationship discerned from Exhibit 5.5 was that the administrators of the three categories of nursing homes gave varying degrees of importance to the seven factors. With respect to the two medical factors, the ratings given these two site factors by the three categories

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[7]U. S. Senate, Special Committee on Aging, New Population Facts on Older Americans, 1960, Washington, D. C., May 24, 1964, pp. 2-5.

of administrators are consistent with the needs of their respective target markets. Intensive care homes have patients requiring a maximum amount of medical care, and the administrators of these homes rated the two medical factors more important than did the administrators of the other two categories of homes. The conclusion here is that administrators do consider the needs of their target market when selecting a site for a nursing home.

The ratings given to accessibility of the site and the attractiveness of the land are again consistent with the needs of the home's target market. Patients in intensive care homes are generally confined to the nursing home. These are the patients to whom the accessibility of the home to visitors is most crucial and who desire the most pleasant surroundings. These patients pay more and expect more. For this reason, the administrators of intensive care homes consider accessibility and attractiveness of the site more important than the administrators of the other homes. These results again support the conclusion that administrators do consider the needs of their patients when selecting a site.

The price of a site was the only factor where the administrators of minimal care homes gave a higher rating than the other administrators. Two factors help explain these ratings of the price of a site. First, the administrators

of minimal care homes gave the first four factors (convenience for doctors, closeness to the hospital, accessibility and attractiveness of the land) lower relative ratings than the other administrators. For this reason, administrators of minimal care homes do not have to pay as high a premium for a site with these four attributes as do the other categories of administrators.

Another factor explaining the relationship between the ratings given by the three categories of nursing homes is the price charged by the homes. Minimal care homes are the least expensive of the three categories and have less income to pay for a high-priced site. Intensive care homes are the highest-priced and have greater revenue to absorb the high cost of a site.

SUMMARY OF FACTS

In summary, the above analysis shows that, like the product analysis previously given, medical factors are the primary concern of nursing homes. Following medical factors, attributes of the land rate next in importance in site selection, followed by the price of the land. One interesting result from the survey was the very low rating the closeness to the patient's home in selecting a site.

As shown in Exhibit 5.1, location of nursing homes is the most important factor in attracting patients to a home

after the three product factors discussed in the previous section. All three categories of homes rated location about equally important. Following location, the factor rated next in importance in attracting patients to a nursing home was the price of the home, which is discussed in the following section.

PRICING POLICIES OF NURSING HOMES

The pricing policies of nursing homes involve two aspects. First, a nursing home needs to establish the basic daily charges for the various types of accommodations available. Second, the home must establish policies with respect to charges for miscellaneous special services provided for patients. In the following two sections these two pricing policies, basic and special services, are examined with respect to the surveyed homes.

BASIC PRICING POLICIES

Basic pricing policies of nursing homes involve a daily, weekly, or monthly rate for room, board, and nursing care. This rate is directly related to the type of room the patient is assigned, i.e., private, two-bed, or three or more-bed rooms, and this rate is generally standardized for all patients in the home. Frequently this basic room charge is variable to

an extent depending on the ability to pay and on the degree of care required by the patient. This variability of pricing is declining in use as more nursing homes have set rates similar to that of motels.

EXHIBIT 5.6

BASIC ROOM CHARGES PER DIEM OF FLORIDA NURSING HOMES: AUGUST, 1968

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Type of Room	(Average Daily Room Charges)			
Private	$18.40	$22.19	$18.57	$14.45
Two-Bed Room	12.85	14.96	13.36	10.75
Three-Bed Room	11.14	12.72	11.51	9.81
Average Charge	14.13	16.62	14.48	11.67

Source: Mail Survey of Florida Nursing Home Administrators.

Exhibit 5.6 summarizes the per diem rates for the surveyed nursing homes. As can be seen from this Exhibit, per diem charges vary substantially among nursing homes, with intensive care homes being the most expensive and minimal care homes the least expensive. This relationship between the category of home and the price charged is apparently related to the cost of care provided. Intensive care homes provide an expensive type of medical care, both in the staffing of

the home and in the facilities provided. Intensive care home patients are in need of more care, which increases the cost of caring for them. Patients in minimal care homes do not need as extensive a staff or facilities to care for their needs. From a cost point of view, intensive care patients cost more to be taken care of and need to pay a higher price for this care than minimal care patients.

Any discussion on pricing in nursing homes must take Medicare into consideration. Medicare coverage for nursing home care took effect January 1, 1966, and it has directly affected the costs of nursing home operation and the prices charged by nursing homes.[8] Medicare coverage is restricted to those persons past age sixty-five who are in need of short-term intensive medical care.[9] The numerous restrictions under Medicare limit who can qualify, and this coverage is limited to not more than one hundred days of care, with the patient paying part of the bill after the first twenty days in a nursing home. Medicare reimburses the

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[8]See: Leon Bernstein, "E.C.F. Report on Impact of Medicare," Modern Nursing Home, Vol. 21, No. 6 (November/December, 1967), pp. 113-114.

[9]Pierre Salmon, "The Medical Implications of Medicare," Nursing Homes, Vol. 15, No. 7 (July, 1966), pp. 13-17.

nursing home based on "reasonable costs."[10]

The effects of Medicare on the pricing policies of nursing homes have been numerous. One effect has been the standardization of rates among all patients. Medicare pays only its proportion of the total costs of the nursing home. The effect has been that a nursing home has to charge all non-Medicare patients the same as Medicare patients unless cost differentials can be established. This standardization of charges has removed a certain degree of flexibility from the administrator.

Another effect on the pricing policies of nursing homes has been the effect on costs. Medicare has been a major contributor to the rapidly rising costs of providing medical care.[11] As costs have increased, priced charged to patients have likewise increased. This increase in costs has affected all nursing homes, including those not covered by Medicare.

SPECIAL PRICING POLICIES

As can be seen from Exhibit 5.7, all three categories of homes are not equally likely to charge for special services.

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[10]Mal Schechter, "Reimbursement Formula Has Surprise," Nursing Homes, Vol. 15, No. 6 (June, 1966), pp. 21-40.

[11]"New Limits on Doctor Fees," U.S. New & World Report, (July 14, 1969), pp. 21-22.

Limited care homes are the most likely to charge for special services, and minimal care homes are the least likely to make special charges. The reason for this relationship is again consistent with the needs of the patients in the three types of nursing homes.

EXHIBIT 5.7

NURSING HOMES HAVING SPECIAL CHARGES FOR SELECTED SERVICES, AUGUST, 1968

	Category of Nursing Home			
	All Homes	Intensive Care	Limited Care	Minimal Care
Services	(Per Cent of Homes Charging for Services in Addition to Basic Charges)			
Personal Laundry	43%	48%	50%	27%
Care for Incontinence	32	31	37	27
Handfeeding	15	17	21	4
Care for Bedfast	13	10	24	4
Wheel Chairs	42	48	61	12
Average Per Cent	29	31	39	15

Source: Mail Survey of Florida Nursing Home Administrators.

Minimal care and intensive care homes have a more homogeneous type of patient than limited care homes. That is, the patients in intensive care homes need a maximum amount of medical care, while the patients in minimal care homes only

need a minimum amount of care. On the other hand, the patients in limited care homes are a heterogeneous combination of patients requiring varying degrees of medical care. Since intensive and minimal care homes have such homogeneous types of patients, their basic charges to patients can include numerous standard services. For example, a large proportion of patients in intensive care homes are bedfast, and the charge for this service is included in the basic rate charged to the patients.[12] Patients in minimal care homes generally are not bedfast so these homes do not have to make a charge, since they frequently do not have patients that even fit this qualification. Patients in limited care homes, on the other hand, are rather heterogeneous with respect to the type of care they need. Rather than have the minimal care patients subsidize the intensive care patients, special charges are levied on those patients requiring special services.

SUMMARY OF FACTS

The conclusion that is reached from this analysis is that the surveyed nursing homes follow pricing policies that

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[12]Refer to Chapter IV, pp. 110-112 regarding the medical condition of patients.

are consistent with their target market and with the other components of their marketing mix. Intensive care homes have a rather homogeneous group of patients who need a maximum amount of care. These homes place emphasis on their product mix and have to charge more since they give the patient more. Because of the homogeneity of their patients, these homes have a high enough basic charge so they do not have to make many extra charges for special services and facilities.

Minimal care homes have a homogeneous group of patients needing only a minimum amount of care. These homes do not need to provide their patients with all the services and facilities that other patients need, and for this reason these homes are less likely to have need for extra charges for special services and facilities. Since these homes provide less to their patients than the other homes, minimal care homes charge less.

Limited care homes on the other hand, have a rather heterogeneous group of patients and design their pricing policies to be flexible enough in order to have each patient pay a reasonable price according to his needs. These homes have a basic charge that is between the rates charged by intensive and minimal care homes and are the most likely category of homes to charge for special services and facilities.

PROMOTION POLICIES OF NURSING HOMES

The fourth area of the marketing mix of nursing homes concerns the promotion of the home, including advertising and other methods of promoting the facility. This factor, promotion, rates a minor role in the marketing mix of nursing homes, as can be seen from Exhibit 5.1. The administrators of the surveyed homes rated promotion as the least important of the six factors that attract patients to a nursing home. Of the surveyed homes, approximately half do not advertise at all. Less than half of the minimal and intensive care homes advertise, but over half of limited care homes do advertise. Most advertising that is done is of a restricted nature. Practically no television advertising is being done, and the advertising that is used is limited primarily to inexpensive areas such as the Yellow Pages.

SUMMARY OF FINDINGS

In Chapter IV, the nursing home market was segmented based upon the medical needs of patients, and the surveyed homes were categorized into one of three groups based upon the market segment of the homes' patients. In Chapter V,

the marketing strategy of these three categories of nursing homes was analyzed. The objective was to analyze for differences in the marketing mixes of the three categories of nursing homes.

Intensive care homes had patients requiring a maximum amount of medical care, and the marketing mix of these homes was designed around the medical needs of their patients. Administrators of intensive care homes considered medical factors as the focal point of their marketing mix. These homes provided numerous medical services, personal services, and facilities needed by intensive care patients.

The location of intensive care homes was selected with emphasis on medical factors. The primary factors influencing a site for intensive care homes was the convenience of the site for doctors and closeness of the site to a hospital. Price of the site and convenience for the patient was rated less important than the medical factors.

Since intensive care homes provide so much in the line of medical care to their patients, these homes are expensive when compared to the other categories of homes. The average per diem rate in intensive care homes was forty-three per cent higher than the rate charged by minimal care homes.

The patients in minimal care homes require a minimum amount of medical care, and the marketing mix of these homes

is designed around this factor. Unlike intensive care homes where the patients required a maximum amount of care and the marketing mix of these homes was designed around the medical factors, minimal care homes designed a marketing mix less medically oriented. Medical factors were important in the design of the marketing mix of minimal care homes, but not nearly as important as was the case with intensive care homes.

The product mix of minimal care homes was less medically oriented. Fewer medical services and fewer facilities were provided the patients. The administrators of minimal care homes rated medical factors less important in the selection of a site than did the administrators of intensive care homes. Minimal care homes considered price important in selecting a site since these administrators did not feel like paying a premium for a site with certain medically oriented attributes. The price for patients in minimal care homes was less than for patients in intensive care homes since minimal care patients need less care and do not have to pay the high price of medical care.

Limited care homes had patients whose needs fell somewhere between the extremes represented by intensive and minimal care homes. Because the needs of the patients in limited care homes were heterogeneous, the marketing mix was designed in a broad fashion so as to appeal to all types of patients.

That is, the marketing mix was more medically oriented than was the mix of minimal care homes but less medically oriented than the mix of intensive care homes.

The product mix of limited care homes included more services and facilities than minimal care homes but less than intensive care homes. The considerations for a nursing home site were less medically oriented than intensive care homes but more so than with minimal care homes. The pricing policies of limited care homes likewise fell somewhere between the pricing policies of intensive and minimal care homes.

The conclusion reached in the analysis of the surveyed Florida nursing homes was that nursing homes do design their marketing mix around the needs of their patients. Depending on the market segment that the home has selected as its target market, the mix was appropriately designed. The greater the medical needs of the patients, the more medically oriented was the marketing mix of the nursing home.

CHAPTER VI

SUMMARY OF THE STUDY

In this chapter, the findings of the study are reviewed. This dissertation was an investigation of the marketing strategy of Florida nursing homes, and the objective was to conduct a foundation study of the marketing of the fast-growing, little-researched field of nursing homes. This study was conducted for two basic purposes. First, the study was a pioneer effort relative to marketing by nursing homes, and second, the research helps extend marketing knowledge of service industries. Service industries have received only limited study by marketing researchers.

Since little is published on marketing in nursing homes, the basis problem investigated in this study concerned the role of marketing in nursing homes. The method of researching this problem was to analyze the marketing strategy of Florida nursing homes. The hypothesis investigated was that the target market of nursing homes was defined in terms of the medical needs of patients and a marketing mix was designed around these target markets.

METHODOLOGY OF THE STUDY

The methodology of this study consisted of defining the marketing strategy concept as applied to nursing homes, collection of the primary data, and the plan of analysis. The following three sections review these three components of the methodology.

MARKETING STRATEGY OF NURSING HOMES

The primary concept on which this study was based was the marketing strategy of nursing homes.[1] Marketing strategy consists of two steps, first defining a target market, and second, selecting an appropriate marketing mix to appeal to the target market. The target market for nursing homes is an identifiable, relatively homogeneous segment of the total potential nursing home market. For the nursing home industry, there are numerous approaches of segmenting the market, including sex, race, religion, income, medical condition, and source of payment. For this study, the most effective method of segmenting the market was the

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[1]Refer to Chapter I, pp. 9-11.

medical needs of the patients.[2]

After the market has been segmented and a target market has been defined, a marketing mix appropriate to the needs of this target market is selected. The marketing mix consists of those marketing tools that the firm uses in order to satisfy the needs of the target group. There are basically four components of the marketing mix. The product component is the most important and includes the nursing care provided, the physical facilities, and the personal services available to patients. The location component of the mix involves the factors that affect the choice of a site for a nursing home. The other two major components of the marketing mix are the pricing and the promotion policies of the home. For a marketing strategy to be effective, a nursing home must design and combine these components of the marketing mix in a manner that effectively satisfies the needs of the target market.

COLLECTION OF THE DATA

Empirical research was conducted in order to test the hypotheses of this dissertation. The primary data used in the analysis was collected from a sample of Florida nursing

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[2]Refer to Chapter IV, pp. 104-107.

home administrators.[3] The study was limited to nursing homes in Florida since Florida had a large number of nursing homes of diverse types of operation. The data was collected by use of a mail questionnaire which was sent to all Florida nursing homes, a total of 282 homes. An up-to-date mailing list was obtained from several sources including the Florida State Board of Health, Medicare, and the Florida Nursing Home Association. Thirty-six per cent of the surveyed homes responded to the questionnaire, and a total of ninety-seven usable questionnaires was obtained.

Comparison of the sample of nursing homes with all Florida homes with respect to size, ownership, and geographical dispersion indicated that the sample of homes was fairly representative.[4] The only apparent bias in the sample was in favor of larger nursing homes. Whereas 44 per cent of all Florida nursing homes had less than fifty beds, only 32 per cent of the sample of homes had less than fifty beds. Other biases may exist in this sample of nursing homes, and this unknown factor was a major limitation of this study.

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[3]Refer to Chapter I, pp. 17-20.

[4]Ibid.

PLAN OF ANALYSIS

The analytical portion of this study consisted of three steps. First, market conditions of the nursing home industry in Florida were examined, and this consisted of an examination of the competitive environment in which nursing homes operate. Secondary sources of information were used to analyze the types of nursing homes operating in Florida and to analyze the characteristics of the patients in Florida nursing homes. The supply of nursing homes in Florida counties was correlated with selected other statistics. These statistics were then correlated with the need for nursing homes in the various Florida counties. The supply of Florida nursing homes by county was then compared with the need for nursing homes.

The remainder of the analysis consisted of an investigation of the marketing strategy of the surveyed Florida nursing homes. First, the nursing home market was segmented in order to identify a nursing home's target market. The surveyed nursing homes were then categorized according to the target market represented in their nursing home. Three categories, intensive, limited, and minimal care homes, were identified. These categories were compared with respect to characteristics of patients, size and ownership of the homes, market area factors, and seasonal variations in the homes.

The final analytical portion of this study consisted of an analysis of the marketing mix of the three categories of nursing homes. The mix was divided into six components, and each component was analyzed for the surveyed homes. The medical care, personal services, and physical facilities made available to patients by a nursing home were compared for the three categories of homes. Location of a nursing home was analyzed according to the factors that influence the choice of a site. Pricing policies of nursing homes were compared by basic charges and by pricing policies with respect to special services and facilities. Finally, promotion policies of nursing homes were examined. The policies of all three categories of nursing homes were compared with regard to these components of the marketing mix in order to identify the marketing strategy of nursing homes according to their target market.

THE MARKETING STRATEGY OF FLORIDA NURSING HOMES

The results of this study are summarized in three sections. First, market segmentation of the Florida nursing home market is examined with respect to the nature of the target market a nursing home has selected. Second, the marketing mix of the surveyed homes is analyzed according to the target market the home has selected. Third, the

marketing strategy is evaluated in light of the historical evolution of nursing homes and the current market condition existing in the industry.

THE TARGET MARKET OF FLORIDA NURSING HOMES

The first essential step in establishing a marketing strategy for nursing homes is defining a target market. The idea behind defining a target market is that a nursing home can more effectively cater to the wants of some limited homogeneous segment of the total market than attempt to cater to the wants of all possible nursing home patients. The procedure in selecting a target market is to first segment the nursing home market into relatively homogeneous segments and then select the segment or segments in which the nursing home can most effectively and profitably specialize. The purpose of this portion of the analysis was first to establish what was the most effective method of segmenting the market and second, to establish whether nursing homes actually did specialize in one market segment.

There exist numerous methods by which to segment the nursing home market, but for this study the most effective and useful method to segment the market was by the medical needs of the patients.[5] That is, the segmentation was based

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[5]Refer to Chapter IV, pp. 104-107.

on how much care was required to handle a patient in a nursing home. Two reasons account for the choice of this method of segmentation. First, this method focuses on the needs of the patient rather than on some descriptive characteristics of the patients. By segmenting the market based upon consumer needs, the nursing home is in a better position to be able to understand and provide for the patient. A second justification is that this method allows the nursing home to design its marketing mix around the target market. Since this method of segmenting is based on the patient's needs, the marketing mix can be effectively designed around these patient needs.

Four selected characteristics of the patients in the surveyed nursing homes were used to identify the segment of the market in which the home specialized.[6] The four characteristics, which were the proportions of patients classified as bedfast, ambulatory, Medicare, and having transferred to a home from a hospital, were indicators of the degree of medical care required by the patients in the nursing home. Based on these four statistics, each nursing home was classified as specializing in patients requiring

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[6]Refer to Chapter IV, pp. 107-109.

either intensive, limited, or minimal care. The objective of this classification process was to test whether nursing homes specialized in a particular segment of the market.

The classification of nursing homes into intensive, limited, and minimal care homes was effective. That is, these four patient characteristics did indicate the target market of a nursing home. Intensive care homes had 92 per cent more bedfast patients, 40 per cent fewer ambulatory patients, three and one-half times more patients who transferred to the home from a hospital, and twenty-five times more Medicare patients than minimal care homes.[7] These statistics indicated that patients in intensive care homes required substantially more medical care than patients in minimal care homes. The patients in limited care homes were classified between the extremes represented by intensive and minimal care homes.

The conclusion reached from the above classification of nursing homes was that each nursing home did specialize in a particular segment of the market. Since the above method of classifying nursing homes was effective, this supports the

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[7]Refer to Chapter IV, pp.110-119.

hypothesis that nursing homes define their target market in terms of the medical needs of the patients.

After the surveyed homes were categorized with respect to their target markets, the three categories of homes were compared for significant differences. Aside from characteristics of patients, which were used to classify the nursing homes, the only significant difference among the three categories of homes was in their average size. Intensive care homes were the largest nursing homes with an average size of ninety-four beds, and minimal care homes were the smallest with an average size of sixty-four beds.[8] This difference in size between intensive and minimal care homes is related to the economies of scale available in providing more intensive medical care.[9]

Analysis of the ownership and market area factors of the three categories of nursing homes indicated few differences in the homes. The majority of all three categories of homes were proprietary rather than non-profit institutions,[10] were located in medium-sized cities with populations from

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[8]Refer to Chapter IV, pp. 117-118.

[9]Ibid.

[10]Refer to Chapter IV, pp. 121-122.

100,000 to 500,000,[11] and obtained most of their patients from within a twenty-five mile radius of their home.[12] There was, however, a difference in the degree of seasonal variation experienced by the three categories of homes.[13] Over twice as many intensive and minimal care homes experienced some seasonal variation than did limited care homes. In the following section, differences in the marketing mixes of these homes are reviewed.

THE MARKETING MIX OF FLORIDA NURSING HOMES

In this section, the marketing mix of the surveyed Florida nursing homes is reviewed according to the target market; intensive, limited or minimal care, of the home. The objective was to test the hypothesis that nursing homes design a marketing strategy such that the marketing mix focuses upon the needs of the target group of patients.

Marketing Mix of Intensive Care Homes

Analysis of the marketing mix of intensive care nursing

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[11]Refer to Chapter IV, pp. 123-125.

[12]Refer to Chapter IV, pp. 125-126.

[13]Refer to Chapter IV, pp. 126-127.

homes indicated that these homes had a mix that was consistent with the needs of their target market. The medical care provided by these homes was more intensive than for the other nursing homes. Intensive care patients needed more medical care, and the homes that specialized in this market segment provided their patients a maximum amount of medical care. With respect to four particular medical services available to patients, intensive care homes were 44 per cent more likely to provide the services than minimal care homes.[14]

The facilities and personal services provided patients in intensive care homes were directly related to the needs of the patients. Intensive care patients were generally confined physically to a nursing home and for this reason were in need of physical facilities and personal services available to them on the premises of the nursing home. Such conveniences as movies, organized activities programs, air conditioning, and room telephones were more frequently available in intensive care homes than in minimal care homes.[15]

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[14]Refer to Chapter V, pp. 141.142.

[15]Refer to Chapter V, pp. 143-145.

Since the product mix, which includes medical care, facilities, and personal services, of intensive care homes reflected the needs of their target market, additional support is given to the hypothesis that nursing homes design their marketing mix around the needs of their target market.

The sub-hypothesis concerning the role of the product mix in the total marketing mix was also supported by the high rating of importance given the product mix by intensive care homes. Intensive care homes rated the three components of the product mix as the most important factors in attracting patients to their nursing homes.[16] The hypothesis that the product mix is the most important component of the marketing mix is corroborated by this rating.

With respect to the location of an intensive care home, the administrators of these homes placed consideration for doctors and for a hospital as being of primary importance.[17] The administrators considered these factors the most important considerations in selecting a site and were willing to pay a premium for a site with these attributes. Again, these administrators were looking toward their target market, which was in need of being catered to by doctors and being close to

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[16]Refer to Chapter V, pp. 133-140.

[17]Refer to Chapter V, pp. 149-155.

the services of a hospital.

The pricing policies of intensive care homes were consistent with the nature of their target market and with the other components of the marketing mix. Intensive care homes had an average per diem charge of $16.62, which was 43 per cent higher than the average charge in minimal care homes.[18] Intensive care patients received more care and facilities than minimal care patients and for this reason paid more. Since intensive care patients were rather homogeneous in their needs, these homes generally had an all-inclusive charge rather than one basic charge and separate charges for extra services and facilities.[19]

Marketing Mix of Minimal Care Homes

Minimal care homes had patients at the opposite extreme of intensive care homes with respect to their medical needs. These minimal care homes had a marketing mix that differed from the mix provided by intensive care homes and that was more directly related to the needs of patients requiring only minimal care. This analysis of the mix of minimal care homes again supports the hypothesis of this

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[18]Refer to Chapter V, pp. 155-158.

[19]Refer to Chapter V, pp. 158-160.

study that the marketing mix is designed around the target market.

The product mix of minimal care homes was appropriate to the needs of minimal care patients. Since the medical needs of minimal care patients were at a minimum, the homes specializing in this market segment did not emphasize medical care in their total product mix as much as other homes. Minimal care homes less frequently provided medical services than did intensive and limited care homes.[20] The situation was similar with the physical facilities of the homes and the personal services provided by these homes. Minimal care patients were generally better able to provide for themselves by leaving the nursing home premises. For this reason, minimal care homes did not have to provide as many services and facilities for their patients as did intensive care homes.[21]

While the product mix of minimal care homes was not as extensive as other homes, minimal care homes still considered their product mix as the most important factor in attracting patients to their homes.[22] As was hypothesized, the product

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[20]Refer to Chapter V, pp. 141-143.

[21]Refer to Chapter V, pp. 143-147.

[22]Refer to Chapter V, pp. 134-139.

mix was the most important component of the marketing mix.

With respect to the location of minimal care homes, doctors and hospitals were important considerations to these homes but not to the extent of intensive care homes.[23] Minimal care homes were more price-conscious than intensive care homes and were not as willing to pay a premium for a site that had certain medically-oriented attributes. Minimal care homes were the least expensive category of nursing homes, with an average daily charge of $11.67[24] and were the homes providing the least in terms of services and facilities to their patients.

Marketing Mix of Limited Care Homes

Limited care nursing homes are the "general store" type of nursing home that has a few of all types of patients. Some of these patients need intensive care and some need very little care, but the majority fall somewhere between the two extremes with respect to the care needed. The marketing mix developed by these nursing homes was again consistent with the needs of these patients.[25]

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[23]Refer to Chapter V, pp. 149-154.

[24]Refer to Chapter V, pp. 155-158.

[25]Refer to Chapter V, pp. 140-162.

Limited care homes consistently fell between intensive and minimal care homes with respect to the degree and extent of medical care, facilities, and services provided for patients. The importance of the factors considered in selecting a site fell relatively between the factor ratings given by intensive and minimal care homes. These homes had basic prices between those charged by intensive and minimal care homes, but they more frequently charged for certain special services than the other homes. Limited care homes had a heterogeneous mixture of patients, and for this reason these homes did not standardize their rates as did intensive and minimal care homes which had homogeneous types of patients.

Summary

The above summarized findings provide support for the primary hypothesis of this study that nursing homes have a marketing mix designed around the needs of their target market. Intensive care homes had a marketing mix that was tailored to the needs of patients requiring intensive medical care. Minimal and limited care homes likewise had mixes that were appropriate to the needs of their target markets. Support of the sub-hypotheses concerning the relative importance of the components of the marketing mix has also been provided. All the homes considered their product mix as the most important factor in attracting patients to their home. Location of the

homes was considered second in importance, and price was third in importance. Promotion was considered practically unimportant in attracting patients. In the following section, insight into why these marketing strategies have evolved is provided.

FORCES BEARING ON THE DEVELOPMENT OF THE MARKETING STRATEGY FOR NURSING HOMES

The previous two sections in this summary reviewed the marketing strategy for Florida nursing homes. In this section insight is provided into why the nursing homes have developed such marketing strategies by reviewing the historical evolution of nursing homes and the present market conditions in the nursing home industry.

Numerous forces have contributed to the development of nursing homes. Medical knowledge has increased substantially in recent decades, and medicine has been able to control infectious diseases, such as tuberculosis; but now people survive to the stage of chronic diseases, such as cancer and arthritis.[26] The chronic diseases require long-term care of the aged which is different from the short-term

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[26]Refer to Chapter II, pp. 47-48.

needs of the infectious diseases. As the aged started living longer and began to need long-term care, nursing homes evolved to provide for these needs. Hospitals during this period began to specialize as institutions providing short-term care.

While medical advances lengthened man's life, the number of aged grew both absolutely and relatively in the United States.[27] The population aged sixty-five and over is presently approaching twenty million in the United States and has been growing since 1900 three times as fast as the total U. S. population. While the aged population was growing, certain economic and social changes came about that helped create a demand for nursing home care. Retirement became institutionalized as the retiree became dependent upon pensions or other non-working sources of income. As institutions have developed to provide for the retiree's needs when he grew old, so nursing homes have evolved to provide for his medical needs.[28]

Social forces have also contributed to the evolution of nursing homes.[29] Family changes have come about such

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[27]Refer to Chapter II, pp. 32-36.

[28]Refer to Chapter II, pp. 44-47.

[29]Refer to Chapter II, pp. 48-52.

that the aged are now more independent in old age and are not living with, and dependent upon, their relatives. The family is no longer available to care for the aged in his old age, and nursing homes have evolved as a substitute for care of the aged.

In summary, nursing homes have evolved because of the changing medical needs of the growing number of aged and the need for an institutional solution to these needs. Nursing homes have evolved as medical institutions providing care for the aged. They are primarily medical institutions, and for this reason medical factors are the focal point of the firm's marketing mix. The product mix, the choice of a location of a home, and the prices charged by a home are directly concerned with medical factors.

An understanding of why nursing homes have evolved into the type of industry that they are today provides insight into and support of the hypothesis concerning the existence of the three types of target markets: intensive, limited, and minimal care. Intensive care homes have evolved because of the changing medical needs of the aged. The aged are living longer and are needing more medical care, and hospitals are unable to satisfy all the demand for this type of care. Intensive care homes are specializing in this market. Minimal care homes have evolved because of the

changing social and economic conditions. The family of the aged no longer takes care of them, and an institutional solution for this need is the reason why minimal care homes have evolved. Limited care homes are a cross between the intensive and minimal care homes, and for this reason they have evolved for a combination of reasons.

The nursing home industry is in a state of transition. The industry is operating in many market areas in a sellers' market as the demand for nursing homes has grown very rapidly. The analysis of the supply of nursing homes in Florida relative to the needs in the state indicated only 67 per cent of the nursing home bed needs in Florida was met.[30] Only five of the fifty-three market areas analyzed had a supply of beds sufficient to the needs of the market. This sellers' market environment has been further stimulated as the government has increased its role in the industry by providing funds for patient care.[31] As financial limitations of the potential market are removed, the demand for nursing homes continues to grow.

This transitional state of the nursing home industry has affected the nature of the marketing mix of nursing homes.

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[30]Refer to Chapter III, pp. 90-100.

[31]Refer to Chapter III, pp. 79-90.

The lack of a competitive environment, for example, has decreased the importance to administrators of promoting their nursing homes. These nursing homes just offer a service to patients and do not worry about their promotion, location, or price to the same extent that might be required by a competitive environment.

New money is entering the nursing home industry as new national corporations move into the nursing home field. As these corporations enter the industry, a more sophisticated approach to nursing home management is being applied. New management is entering the industry and is able to develop a conscious, long-range marketing strategy. As this occurs, and as the demand for nursing home beds becomes satisfied, the industry will become more competitive, and the marketing of nursing homes will become more crucial for the home's survival.

SIGNIFICANCE OF THIS STUDY ON THE MARKETING OF NURSING HOMES

The significance of this study is two-fold. First, this study has investigated the marketing policies of the relatively new, fast-growing, and little-researched nursing home industry. Practically no studies have been conducted on marketing in the nursing home industry. Most research

that has been conducted has been medically oriented or on some other technical aspect of nursing home operations, such as food service. Marketing strategy is to a large extent a philosophy of operation, and this study examines what is the philosophy of operation in nursing homes. The research provides administrators with additional insight into the operation of their business.

The second contribution of this study concerns the additional knowledge provided by this research on the marketing strategy of the little-studied service industries. Little marketing research has been done on any aspect of the medical field. The marketing of this service industry, nursing homes, is indeed very similar to that of product industries where a tangible product is involved.

SUGGESTIONS FOR FURTHER RESEARCH

This study has been a basic study of the marketing of nursing homes. No other study of this nature on nursing homes has been conducted, and the whole field of the nursing home industry is wide open for research. First, a more thorough and detailed study of the same type of this present investigation is needed. A groundwork for further research has been laid by this dissertation.

Studies are needed on all aspects of the marketing of nursing homes. This includes studies of location, product, pricing, and promotion policies of nursing homes. One study in particular is on the forces that directly affect the choice of a home by a patient. One question to be examined concerns the role of the physician in the selection of a nursing home. The problem is whether a nursing home should focus its marketing efforts with respect to location and advertising toward the physician or toward the patient directly. A more basic question is just what are the forces that affect a patient's choice of a nursing home.

This study has analyzed the two components of marketing strategy: the target market and the marketing mix. Whether this strategy was part of a planned effort of management, however, was not determined. Because the industry is dominated by small independent operators, the management of a home may be so involved with day-to-day operations that the home does not consciously implement its marketing strategy. The question to be investigated is whether the marketing strategy of the firm is a conscious effort of administrators or an unplanned strategy that has come about because of market forces.

Another direction for further research is on other service industries, medical fields in particular. For example,

what is the marketing strategy of physicians or of hospitals. Many fertile fields remain to be researched with respect to service industries.

CONCLUDING COMMENTS

This study has been an investigation into the marketing strategy of nursing homes, and the objective was simply to investigate how nursing homes are marketed. The conclusion of the study was that nursing homes do follow a marketing strategy such that the marketing mix of the firm is designed around the needs of the target market.

The industry is in a state of transition, and so is the role of marketing within the nursing home industry. As the industry grows and develops into a mature industry, a planned, well thought-out marketing strategy needs to be developed. This study has hopefully helped to stimulate thought along the lines of developing a philosophy of operation that focuses around a marketing strategy.

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APPENDICES

APPENDIX A

CONFIDENTIAL QUESTIONNAIRE

AN ANALYSIS OF THE MARKETING STRATEGY OF FLORIDA NURSING HOMES

This is an investigation of marketing policies in Florida nursing homes. The research should be of assistance in the development of a better understanding and implementation of the marketing policies of an important growth industry. The results of the investigation are being made available to interested nursing homes, on request. Your completion of the following questionnaire is very much appreciated.

The information from this questionnaire will be held in the strictest confidence. All data collected will be used in collective form only and no company or personal information will be identified. Neither your name nor the name of your institution is asked for in this questionnaire.

The questionnaire requires only a few minutes to complete. Most questions can be answered simply by a check in the approriate space. There are no right or wrong answers. Where specific values are called for, approximate the value.

1. City where nursing home is located: _____
2. Administrative title of person completing questionnaire: _____
3. Number of beds: _____ 4. Is your home Medicare certified? _____Yes ____No
5. At the present time, how many beds and patients do you have in the following classifications?

	Number of Beds	Number of Patients
Private rooms	_____	_____
Semi-private (2-bed) rooms	_____	_____
Other (3 or more beds)	_____	_____
TOTAL	_____	_____

6. Do you experience during the year a seasonal change in the number of patients you have in your home?___Yes___No

7. If the answer to question 6 is yes, rate the following periods as to the number of patients you have in your home. Check the appropriate space.

	NUMBER OF PATIENTS		
	Below Normal	Normal	Above Normal
January-March	_____	_____	_____
April-June	_____	_____	_____
July-September	_____	_____	_____
October-December	_____	_____	_____

8. Estimate the range of your basic daily room rates.

Private room _____
Semi-private (2-bed room _____
Other (3 or more beds _____

9. Check the appropriate space to indicate the type of ownership of your home.

_____Profit-making, family owned business
_____Profit-making, closely held firm (less than 4 unrelated owners)
_____Profit-making, widely held firm (more than 4 unrelated owners)
_____Religious sponsored home
_____Government owned home
_____Other, please specify:_____

10. The top administrator of your nursing home would fall in which of the following classifications? Check the appropriate space.

_____Owner-operated _____Lessee
_____Hired management _____Other

11. How many nursing homes are owned by the same individual who owns your home?_____.

12. What per cent of your patients are referred to your home by the following sources;

Doctors	_____
Hospital	_____
Church	_____
Friends and relatives of patients	_____
Other, please specify:	_____
_____	

13. Check the services and facilities provided for your patients either free or with an extra charge.

	Not Available	No Charge	Extra Charge	Comments
Physical therapy	_____	_____	_____	_____
Wheel chairs	_____	_____	_____	_____
Laboratory	_____	_____	_____	_____
X-ray	_____	_____	_____	_____
Occupational therapy	_____	_____	_____	_____
Care for bedfast patients	_____	_____	_____	_____
Handfeeding	_____	_____	_____	_____
Care for incontenence	_____	_____	_____	_____
Library	_____	_____	_____	_____
Personal laundry	_____	_____	_____	_____
Television: in lounge	_____	_____	_____	_____
each room	_____	_____	_____	_____
Telephone in each room	_____	_____	_____	_____
Air conditioning	_____	_____	_____	_____
Beauty shop -barber shop	_____	_____	_____	_____
Church services	_____	_____	_____	_____
Movies	_____	_____	_____	_____
Organized activities program	_____	_____	_____	_____
Carpeting in rooms	_____	_____	_____	_____
Shuffleboard	_____	_____	_____	_____
Other:_____	_____	_____	_____	_____

14. Is a majority of your patients of a single religious belief? _____Yes_____No.

15. If the answer to question 14 is yes, what is the majority religion of your nursing home?_____

16. What per cent of your patients enter your nursing home directly from the hospital?_____

17. Estimate the average per cent of your patients that fall within the following classifications. Make a rough approximation of these values.

Medicare patients	_____	Long-term, permanent	_____
Welfare patients	_____		
Ambulatory patients	_____	Non-white patients	_____
Bedfast patients	_____		
Female patients	_____	Under age 65 patients	_____
Short-term, convalescent	_____		
		Very confused patients	_____

18. Does your nursing home advertise? _____Yes_____No

19. If the answer to question 18 is yes, which of the following media do you use?

	Do Not Use	Occasionally Use	Regularly Use
Radio	_____	_____	_____
T-V	_____	_____	_____
Newspaper	_____	_____	_____
Other:_____	_____	_____	_____

20. Estimate the per cent of your patients whose residence prior to entering your home was within the following distances:

Less than 10 miles from your nursing home	_____
Ten to 25 miles from your nursing home	_____
Over 25 miles from your nursing home	_____

21. Rate the following factors as to their importance in the site you would select for a nursing home. Check the appropriate degree of importance.

	Unimportant	Below Average	Average	Above Average	Very Important
Price of the land	_____	_____	_____	_____	_____
Closeness to hospital	_____	_____	_____	_____	_____
Convenience for doctors	_____	_____	_____	_____	_____
Closeness to business center	_____	_____	_____	_____	_____

	Unimportant	Below Average	Average	Above Average	Very Important
Attractiveness of land	_____	_____	_____	_____	_____
Closeness to patient's home	_____	_____	_____	_____	_____
Accessibility of land	_____	_____	_____	_____	_____

22. Check the three most important problem areas that you are involved with.

Securing personnel _____ Purchasing ____
Food service operations _____ Managing employees____
Providing nursing care _____ Securing patients_____
Managing employees _____ Public relations _____
Spending time with patients and relatives_____

23. How many nursing home short courses, seminars, and workshops have you attended during the past 12 months? This would include those sponsored by the Nursing Home Association, the State Board of Health, Medicare, and universities.

_____None
_____1 or 2
_____3 or 4
_____5 or 6
_____7 or more

24. Check the highest level of education you have completed.

_____high school or less
_____Less than 4 years of college
_____Completed college
_____Graduate school
_____Other, please specify:_____

25. Check the educational levels you have achieved.

_____High school
_____R.N.
_____M.D.
_____M.H.A. or M.B.A.
_____Other, please specify:_____

26. Which of the following classifications would best describe your visiting hours?

_____Less than 4 hours per day
_____Between 4 and 6 hours per day
_____Over 6 hours per day

27. Stated below are reasons patients enter your nursing home rather than another nursing home. Check the appropriate degree of importance of each reason.

	Unimportant	Below Average	Average	Above Average	Very Important
Price of rooms	_____	_____	_____	_____	_____
Location of home	_____	_____	_____	_____	_____
Size of home	_____	_____	_____	_____	_____
Reputation of home	_____	_____	_____	_____	_____
Advertising	_____	_____	_____	_____	_____
Quality of nursing care	_____	_____	_____	_____	_____
Services available for patients	_____	_____	_____	_____	_____
Physical condition of home	_____	_____	_____	_____	_____

28. In a few words state why you feel your nursing home is preferred by patients to that of your competitors.

_____

_____

Should you desire a summary of the results of the study, please complete and return the enclosed post card.

APPENDIX B

AMERICAN NURSING HOME ASSOCIATION

Suite 607 / 1025 Connecticut Avenue, N. W. / Washington, D. C., 20036 / Phone: (202) 296-5636

Executive Director
Alfred S. Ercolano

President
Ed Walker

Reply To:

REGION III VICE PRESIDENT
David R. Mosher
New Fern Restorium
859 Tenth Avenue N.
St. Petersburg, Florida 33701

August 30, 1968

To: Nursing Home Administrators
Southeastern United States

Ladies and Gentlemen:

I wish to commend to your attention the enclosed questionnaire being prepared by F. Daniel Miller, a graduate student at Louisiana State University. In the past we have had other questionnaires from graduate students in the various parts of the country and have been asked to help on their graduate dissertations. In this case, Dan Miller's family have been in the nursing home business for years, and he is doing his graduate work in an area that may have information which may be of use to all of us.

If I recommend it to you, you must note it is not to have your name or the home's name on it, or anything else. There is a separate post card to be returned if you wish to have a copy of the summary that is prepared.

Very truly yours,

David R. Mosher
Region III Vice President

DRM:ibw

APPENDIX C

LOUISIANA STATE UNIVERSITY
AND AGRICULTURAL AND MECHANICAL COLLEGE
BATON ROUGE · LOUISIANA · 70803
College of Business Administration
DEPARTMENT OF MANAGEMENT AND MARKETING

August 14, 1968

Dear Administrator:

The recent growth of the nursing home industry underlines its vital role in meeting the needs of our senior citizens. In Florida, your industry is of critical importance due to its large proportion of aged.

The elderly are growing in importance both economically and politically and it is important that you are successful in meeting their demands. Success in your endeavors provides you with a very challenging and rewarding career. This survey represents an investigation into marketing practices in your industry and should help in providing a better understanding and implementation of the marketing strategy of nursing homes.

This study forms the basis of a doctoral dissertation at Louisiana State University and is not connected in any way with the Government. The results of this investigation will be made available to you upon request.

The enclosed questionnaire will only take a few minutes to complete. Your assistance in this survey is essential to the successful completion of a timely and useful study.

Thank you for your cooperation.

Sincerely yours,

F. Daniel Miller

F. Daniel Miller

VITA

Frederick Daniel Miller, son of Mr. and Mrs. Charles Donald Miller, Sr., was born May 30, 1942 in Highland Park, Michigan. He attended public schools in Michigan and Florida and graduated in 1960 from Manatee High School in Bradenton, Florida.

He completed his undergraduate education at the University of Florida in 1964 with a bachelor's degree in business administration. He began his graduate education at Emory University where he received a Master of Business Administration degree in 1965. He continued his graduate studies at Tulane University and then Louisiana State University.

He married Glenda Burton Darsey in December, 1968, and in January, 1969 he assumed the position of Assistant Professor of Quantitative Methods at Georgia State University. He is currently a candidate for the Doctor of Philosophy degree in the Department of Management and Marketing at Louisiana State University.

EXAMINATION AND THESIS REPORT

Candidate: Frederick Daniel Miller

Major Field: Marketing

Title of Thesis: An Analysis of the Marketing Strategy of Florida Nursing Homes

Approved:

C. Glenn Walters
Major Professor and Chairman

Max R. Goodrich
Dean of the Graduate School

EXAMINING COMMITTEE:

Lee Richardson

W. E. Sawyer

Roger L. Burford

Robert F. Smith

Date of Examination:

December 18, 1969