Making Strategic Alliances Work

Strategic alliances among healthcare organizations have proliferated at such a remarkable rate over the past few years that managers and industry analysts have had little time to take stock of the situation.

This past November, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill invited distinguished healthcare executives, business consultants, and academics from throughout the United States to participate in a conference on strategic alliances. The conference's goal was to initiate a dialogue on strategic alliances between the research community and those directly involved in healthcare.

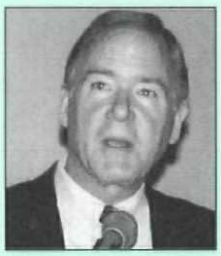
The Need for Vertical Integration

According to William L. Dowling—vice president, planning and policy development, Sisters of Providence Health System, Seattle—pressures to design vertically integrated healthcare delivery systems will continue to be the major factor driving strategic alliance formation.

Two major trends are spurring providers to look for potential partners, Dowling said. "First, increasingly aggressive purchasers are going to curtail their spending to the point that the flow of resources into healthcare will not sustain the delivery system as it is organized today."

The rise of capitated payment systems will create a second motive for increased linkages between healthcare organizations. With providers put at greater financial risk, Dowling predicted, "it will become more and more obvious that today's 'nonsystem' of independent providers is not able to manage care within fixed dollar limits or deploy resources more rationally."

Benefits of Alliances Dowling gave a number of reasons for pursuing vertical integration through alliances, rather than through internal development or some other organizational arrangement. In alliances, he said, "each party brings something to the relationship the others need," enabling participants to acquire important services and capacities "more cheaply, more surely, and at less risk" than they could by developing them internally.



Greater access to payers gives providers more input into product development and marketing strategy decisions, said William L. Dowling.

That alliances can spur development is another attractive feature for organizations trying to create an integrated delivery system, Dowling suggested. Alliances can often "achieve the critical mass or market presence required to produce benefits for the participating parties" sooner than an individual organization could on its own, he said. Alliances also produce synergies and other intangible benefits unavailable to organizations operating alone. Finally, they give rise to a structure flexible enough to respond to the great variety of community needs or marketplace demands.

Alignment of Finance and Delivery Dowling said it is useful to think of vertically integrated systems as comprising three distinct types of alliances: those linking various providers, facilities, and programs that make up the care continuum; those linking physicians to the delivery system; and those integrating the financing and insurance mechanism into the system.

A number of benefits accrue to systems that effectively integrate the financing and insurance mechanism into the overall system, Dowling said. Such integration enables providers to become "direct participants in the design of interfaces between themselves as sellers and employers and other purchasers as buyers." Greater access to payers, he added, also gives providers more input into product development and marketing strategy decisions and greater influence with purchasing alliances.

A well-integrated finance and delivery system also enables providers to "direct marketing and contracting strategies in ways that further their mission," Dowling said. For example, a system committed to serving the elderly and the poor may attempt to align with managed care plans for Medicare and Medicaid recipients.

A close relationship between the delivery system and the financing and insurance component

also encourages "alignment of physician and hospital financial incentives and the rational deployment of resources," Dowling said. In addition, such a relationship enables the delivery system to replace external—and often intrusive—utilization controls with internal self-regulation. And it cuts costs by streamlining interactions between purchasers, payers, and providers. Finally, linkages with payers "position providers to be a part of multiple plan offerings," Dowling said.

Although controlling both finance and delivery is essential to a mature integrated delivery system, the system need not be the ultimate source of funds for healthcare coverage, nor does it have to own an insurance or health plan entity, he noted. "The key," Dowling stressed, "is that the delivery system be at risk for the cost of providing care to enrollees and at the same time be in a position to control the methods and levels of payment for the system's providers." Such a combination of risk and control, he said, will motivate and enable a delivery system to "align provider incentives with the system's utilization goals and treatment protocols."

Forms of Strategic Alliance

Providers considering partnership with other healthcare organizations need to be aware of the options available, as well as the strengths and weaknesses of various kinds of alliances, Barry A. Stein told the audience.

Stein, author of *Life in Organizations* and *Quality of Work Life in Action* and president of Good Measure, Inc., Boston, described three "generic forms" alliances generally take: Those involved can *pool* resources; they can *ally* to take advantage of a specific opportunity; or they can *link* their systems through partnerships.

Pools In alliance pools (such as multihospital purchasing groups), members establish an organization that meets a need none of them could satisfy alone. In addition to achieving economies of scale, alliance pools leave members relatively independent. As a result, entry into an alliance pool requires the fewest internal changes for participants, Stein observed.

The downside is that participants in a pool frequently have little stake in the alliance itself and thus little motive for consensus building. Stein noted that the difficulty in reaching consensus on suitable services can make alliances difficult to manage and lead members to lose interest.

Allies In the second type of alliance, partners become allies to accomplish a specific goal and, in some cases, to share knowledge and expertise. Stein cited joint ventures as the "generic example," where "partners get from each other a competence that helps them move more quickly toward their own business goals." He noted, however, that in some instances "the allying approach is more passive," providing a basis for participants to "learn from one another without initially doing anything different."

Entry into an alliance pool requires the fewest internal changes for participants, observed Barry A. Stein.

Linkages Linkages form between partners that are already interdependent because they are stakeholders in a common business process. Stein pointed out that many American businesses are forming closer relationships with their suppliers to cut costs and improve quality. In some cases, they are inviting customers to help design services to fit their needs. Finally, at a number of companies management and labor organizations are teaming up to work out policy issues or administer certain operations.

Alliances' Usefulness

Stein suggested four basic reasons for strategic alliances' usefulness: They are temporary rather than permanent, they allow organizations to be more flexible and to leverage their existing resources, they deliver benefits that are normally unavailable or prohibitively expensive, and they open up new relationships and markets.

Pitfalls Despite their potential advantages, many

THE SEVEN I's OF STRATEGIC ALLIANCES

Managing the fragile relationships in partnerships and strategic alliances is indeed a delicate balancing act. Successful partnerships tend to have "seven I's" in place.

- The relationship is *Important*, and therefore it gets adequate resources, management attention, and sponsorship; there is no point in going to the trouble of a partnership unless it has strategic significance.
- There is an agreement for longer-term *Investment*, which tends to help equalize benefits over time.
- The partners are *Interdependent*, which helps keep power balanced.
- The organizations are *Integrated* so the appropriate points of contact and communication are managed.
- Each is *Informed* about the plans and directions of the other.
- The arrangement is *Institutionalized*—bolstered by a framework of supporting mechanisms, from legal requirements to social ties to shared values, all of which in fact make trust possible.
- Finally, the relationship is based on *Integrity* in all of its aspects. However much is formalized, alliances always rest as well on personal relationships of trust.

From Rosabeth Moss Kanter and Barry A. Stein, "Strategic Alliances: Some Lessons from Experience," unpublished manuscript, 1993.

alliances have failed to produce benefits, Stein said, because they were undermanaged. "Typically, the arrangement gets a lot of attention from top executives at first. But after it is implemented, people assume it will take care of itself."

Alliances also tend to fail, Stein noted, when there are imbalances of power, such as when one partner has more resources, information, and capital. "This is not a psychological variable," he said. "Commitment here is the kind of commitment that's expressed in hard cash."

Unequal benefits are another source of trouble. The rationale for alliances, Stein said, is to produce synergies that create advantages for all parties. "When it is clear that the arrangement is not leveraging all partners' resources, the alliance tends to collapse quickly because the motive for being part of it disappears."

Weak institutional safeguards and overreliance on personal chemistry tend to undermine alliances as well. "We have a vast confusion in industry and organizations in general between what it means for the *people* to be working together and collaborating and for organizations to be working together."

Another potential problem is that organizations which enter strategic alliances tend to have a number of partners, Stein said. "There are commitments in all directions," he noted. "People and organizations both are members of different groups and constituencies." These competing allegiances create structural problems and raise the issue of how to balance obligations.

Management of Alliances Alliances need constant attention, Stein stressed. And the tighter, stronger, and more far-reaching the partnership, the more care it requires. The increasing activity occurring across rather than within organizational boundaries will compel managers to learn how to work with partners rather than subordinates. At the same time, they will have to cope with changes within their own organization brought about by the dynamics of the partnership itself.

"Important external relationships," Stein noted, require managers "to juggle more factors, allow for variation in their systems, and explain why people and projects are treated differently." Stein stressed that the challenges inherent in managing partnerships can become insurmountable if the relationship lacks "standards at the boundaries that all agree on." He noted that the United States lags behind most other developed countries in development of constructive regulations governing interorganizational alliances. "We pay an enormous price for this lack of interface standards."

When organizations have a similar vision, even "competitive healthcare business entities can combine into alliance structures to accomplish the alliance's vital purposes," said Harry A. Nurkin.

The absence of such regulations, Stein said, makes it all the more imperative for organizations to focus on a few critical questions: "How do I make myself attractive to others? How do I learn to work with others? How do I link up with those others? How do I make it easy for others?"

Building a Vertically Integrated System

Harry A. Nurkin, president and chief executive officer of the Charlotte-Mecklenberg Hospital Authority (CMHA), Charlotte, NC, suggested that the current move toward integrated systems can help overcome some of the "remoteness and isolation" that developed in the 1980s between hospitals, physicians, third-party reimbursers, and ultimate payers. But he cautioned that organizations searching for potential partners must check first whether their goals and outlooks are likely to mesh.

In 1983 CMHA, which had been a loose affiliation of relatively independent hospitals, developed a long-range plan to expand into a vertically integrated alliance. The plan had four goals:

- Creation of a fully integrated healthcare system
- Financial stability without reliance on tax-based funding
- Maintenance of medical and allied health educational programs
- Improved competitive performance based on clinical competency, organizational efficiency, and growth of facilities and programs

In looking for ways to meet these goals, Nurkin said that he benefited from the advice of several businesspersons in his community who had affiliated, aligned with, or merged with other businesses. "These executives encouraged us to think in a nontraditional, iconoclastic way about how various segments of the fragmented delivery system could possibly be put together in some organized way," Nurkin told the conference.

CMHA launched four separate initiatives to accomplish its goals: (1) to establish a core group of facilities, (2) to establish a core group of primary care and subspecialty physicians, (3) to develop value-added relationships with nonurban hospitals in the Charlotte region as a means of achieving urban-rural institutional integration, and (4) to establish value-added relationships with third-party payers, managed care companies, and direct purchasers of healthcare.

In searching for potential partners, CMHA took its lead from successful integrated systems. "We discovered that the best organizations took

the time to select physicians and institutional partners for whom collegiality and values were higher priorities than autonomy or the ability to buy expensive toys," Nurkin said. When organizations have a similar vision, he said, even "competitive healthcare business entities can combine into alliance structures to accomplish the alliance's vital purposes."

Administrative and Managerial Challenges Nurkin suggested that the biggest challenges strategic alliances present may be administrative and managerial. Managing a system with multiple stakeholders poses special problems and requires a different set of attitudes and competencies from those which achieve results in traditional organizations, he said.

In giving up control, managers and administrators must learn how to share risk, Nurkin said. They must also bypass antagonism and create long-standing and meaningful relationships with parties, such as physicians and third-party payers, with whom they have traditionally been at odds.

"Success in alliance formation will be based more on human interactional theory than corporate dynamics," Nurkin noted. "Learning the process of losing a system that we dearly love and dealing with that loss is very important if we're going to survive."

The changing healthcare system is also compelling administrators to rethink organizational structures. Nurkin said that he has recently begun to study how people form entities or subsystems within larger sets, the characteristics of those subsets, and the characteristics and processes of boundary spanning.

Alliances and Integrated Delivery

In the context of healthcare reform, researchers and managers should think of strategic alliances in terms of how they can help meet the future requirements of an integrated delivery system, Edward J. Connors told the conference.

Connors, retired president of Mercy Health Services, Farmington Hills, MI, identified six key characteristics of an effective integrated delivery network:

1. Comprehensive services
2. A seamless continuum
3. Serious focus on the health status of a defined or enrolled population
4. The ability to go at risk financially within finite resources
5. Accountability to the public for performance in at least three dimensions—meeting explicit access requirements; meeting quality requirements (including standards compliance, clinical protocol and outcome involvement, continuous quality improvement environment, community and customer satisfaction); being accountable for costs
6. An integrated, automated clinical record

The integration of hospital's and physician's economic interest will be "difficult unless it is enforced by a payment and financing system that pays on a capitated basis," predicted Edward J. Connors.

Integration Challenges "To literally integrate the hospital, ambulatory care settings for medical care, nursing home, and home health will stretch our leadership capacity and our management tools—even when all components are owned under a single structure," Connors said. "It will be even more difficult when the structure attempting to achieve those goals is an alliance arrangement involving multiple partners, multiple stakeholders."

The difficulty of integrating the hospital's and the physician's economic interest and incentives will be yet another challenge. Connors predicted that such integration will be "difficult, if not impossible, unless it is enforced in the future by a payment and financing system that pays on a capitated basis."

He added that the evolving delivery system will have to be coordinated with community-based services, including voluntary health, human service, and public health agencies. He noted that an integrated delivery system will also have to support educational initiatives—particularly in health promotion and disease prevention.

"Few organizations can or should try to accomplish these objectives through a single ownership or a unified control structure," Connors advised. He predicted that strategic alliances will be "the norm rather than the exception and one of the few practical tools that we have available to achieve the change called for by healthcare reform."

Connors said he did not believe that delivery and financing integration is essential, although it would be advantageous. To the extent that delivery and financing must be integrated, achieving change will be a more complex and difficult task.

Primary Care Maintaining the distinction between managing benefits and managing care processes will also be important, Connors stressed. "Only the direct providers of care can and should manage the care delivery process."

To manage it well, he said, providers will have to match primary care resources with the demand and the need. He warned that producing more family physicians will not in itself ensure a reasonable standard of access. Networks must also build teams of primary care practitioners that include qualified nurse clinicians, focused physicians assistants, and social workers. Such teams, he advised,

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must operate as a single unit, with a unitary payment source and common incentives.

Connors said that there are few, if any, current models of the kind of primary care component he believes will be critical to the success of integrated delivery in a reformed system.

Governance Connors called on policymakers to give attention to how accountable plans or integrated delivery systems will be governed. "Some criteria and some standards are needed—at least some open discussion about how we choose to govern these systems," he said. "Otherwise, we'll end up with a governance hodgepodge reflective of the most entrepreneurial and powerful force that happens to be available in a given market."

Policies enabling governance structures for integrated systems to be as local as feasible would be the most desirable, Connors said. "I would hope they would be dominated by the community, that citizen leaders would participate in them; that they would be not-for-profit in structure, behavior, and intent; and that they would have the maximum freedom to shape and direct the resources available that reflect those community values."

Connors admitted, however, that the governance structure of an integrated delivery system will most likely reflect the bias of the dominant player in the market, whether it be physicians, hospitals, insurers, state government, or consumers.

But Connors reminded the conference that, with the important decisions yet to be made, it was crucial that participants add their voice to the reform debate. "Let's elevate the challenge in the minds of the research, policy, and operational world. It's a very exciting time for shaping how we wish to define, how we wish to organize, how we wish to structure, how we wish to govern an organization responsible for the health of our communities."

—Phil Rheinecker