Catholic Systems:
Two Years Later

Two Authors Revisit Strategic Planning Issues Raised in a 1998 Health Progress Article

Two years ago, the senior author of this article and a colleague wrote a piece about the emerging Catholic health care systems (David Burik and Amie Thornton, “New Catholic Systems, New Strategic Questions,” Health Progress, July-August 1998, pp. 54-55). We noted that although such systems faced fundamental strategic questions, they were, because of their origins, not well equipped to address those questions. Most Catholic systems, we wrote, began as networks of independent organizations with little more in common than a sponsoring congregation and a need to generate economies of scale and other benefits.

As a result [we continued], system strategic planning was driven largely “from the bottom up.” It focused on defining areas of common need and opportunity through which system action could support the individual strategic agendas of each local institution. . . . Because this planning was largely limited to this overlap among the local institutions’ individual agendas, fundamental choices regarding the future of the ministry were often made exclusively in the context of local strategic planning processes (p. 54).

That kind of planning must change, we argued. “System strategic planning now must be neither top down nor bottom up, but effectively integrated to balance the realities of the local ministry with the common good of the ministry as a whole,” we wrote. “If the new Catholic health systems are to realize their potential, they must face squarely and often controversial choices forced on them by the realities of the market” (p. 54).

Since publishing that article, the senior author and a new coauthor have been involved in planning efforts at several large Catholic systems. They thought revisiting the original article in the light of subsequent practical experiences might be useful.

The Years Since 1998

Along with a handful of for-profit companies, Catholic organizations have led the formation of multiregional and national health care delivery systems in recent years. They have done so despite two developments that have had a generally negative effect on all health care providers:

- The failure of some elements of the integrated delivery system (IDS) model—for instance, physician practices, home health agencies, and managed care itself—to meet financial and strategic objectives
- The negative impact of the Balanced Budget Act of 1997 on the acute care services that continue to serve as the “core” of health care

These two developments have certainly complicated system formation. (Some critics blame U.S. health care’s current troubles on system creation rather than IDS problems or federal budget cuts.) In addition, consolidation has turned out to be less effective for hospitals than for other health-related organizations—pharmaceutical and managed care companies, for example. For those two businesses, consolidation has brought the new capital they require (for drug research, in the first case, and information technology, in the second) to advance into the future. For hospitals, on the other hand, consolidation has primarily been a defensive measure; hospitals have come together in an attempt to preserve themselves. And because they are structured defensively, hospital consolidations have often failed.

For Catholic health care systems, these prob-
The founders of Catholic systems tend to neglect business agendas.

**Fundamental Questions About Systems**

In the 1998 article, "New Catholic Systems, New Strategic Questions," the authors listed nine fundamental questions that should be asked by the leaders of a Catholic health care system. Those questions could be summarized as follows:

- Should a Catholic system include a facility that has a joint operating agreement with another, other-than-Catholic organization?
- Should a system "swap" assets to create stronger regional positions?
- Should a system move capital from one location to another?
- Should a system merge with a much smaller one whose facilities are strategically and financially weak?
- Does the system bring value and benefit to the sponsored local ministry?
- Does the system have an explicit, well-defined growth strategy?
- Does the system have a uniform clinical agenda ensuring that each of its facilities uses the same processes, thereby producing similar high levels of quality and safety?
- Is the system primarily an acute care organization or one primarily involved in improving community health?
- How can the system ensure the continued vitality of its mission and religious identity in a competitive environment?
with which the system’s components—corporate and local—can hold each other accountable.

- “Transformation teams,” recruited from throughout the system (but supplemented as necessary by outside experts), to carry out various tasks (e.g., develop Internet strategy, buy and sell assets, build technology partnerships, create regions in especially large systems).
- A system board that is of manageable size (e.g., nine members) and holds efficient but brief (e.g., three-hour) meetings infrequently (e.g., quarterly). These meetings should follow structured agendas that go beyond reserved powers and address issues that have been thoroughly researched with the aid of transformation teams.
- Operating models that clearly show the organizational levels at which the system’s various decisions are made.
- Identification of services likely to benefit from the system’s size (e.g., medical and information technology).

**RESOLVING STRUGGLES FOR CONTROL**

Large health care systems typically involve three levels of operation: local (a single facility), regional (multiple facilities serving the same market), and multiregional or national. In a new system, consensus on which level should hold efficient but brief (e.g., three-hour) meetings infrequently (e.g., quarterly). These meetings should follow structured agendas that go beyond reserved powers and address issues that have been thoroughly researched with the aid of transformation teams.

- Operating models that clearly show the organizational levels at which the system’s various decisions are made.
- Identification of services likely to benefit from the system’s size (e.g., medical and information technology).

**SPONSORSHIP AND BUSINESS**

Catholic organizations, which currently lead the formation of health care systems in the United States, are nevertheless handicapped by the fact that—unlike competing systems—they must focus on sponsorship issues rather than purely business ones. They must apply this focus, moreover, at a time when health care is becoming an increasingly competitive business.

Of course, Catholic organizations, being mission-driven and sponsor-led, have no choice but to focus on sponsorship issues. Catholic health care systems exist not to provide shareholders with a return, but to serve the systems’ communities. Still, the sooner Catholic systems adopt explicit business transformation agendas and resolve control issues, the better situated they will be to make a positive impact on those communities.

**NOTES**
