Catholic Systems: Two Years Later

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

BY DAVID BURIK & NEAL PEYSER

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 tough 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.

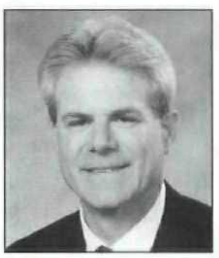
The Years Since 1998

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 business "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-



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lems are frequently exacerbated by two factors:

- The absence of an explicit business transformation agenda
- Unresolved questions concerning control

Needed: A Business Transformation Agenda

The deliberations attending the formation of a Catholic health care system are often protracted, mostly focusing on sponsorship issues. Typically the founders spend much less time developing a *business* agenda. They tend to act as if improving sponsorship was the sole reason for forming the system, as if developing a better business model was somehow a secondary issue that could be dealt with later. As a result, the facilities comprising such systems are structurally unaltered except for having become a new capital financing instrument. Local managers, physicians, and boards therefore wonder whether any real change has occurred at all.

> The founders of Catholic systems tend to neglect business agendas.

In such circumstances, local leaders have trouble seeing how belonging to a system gives them an advantage over local competitors. On one hand, system membership may give a facility access to capital and purchasing discounts. On the other hand, the facility, which perhaps negotiated better discounts when it was independent, may as a member find its financial health threatened by weaker partners. In the latter case, the system may insist that the stronger partner aid the weaker—thus turning the formerly independent facility into a lender of last resort. Even worse, the system may give the former independent no role *except* that of lender.

Even if its inclusion in a system strengthens sponsorship, the leaders of a local facility may be reluctant to increase overhead by adding jobs (in mission effectiveness, for example) that improved sponsorship requires, especially in times of economic hardship. Mission effectiveness goals, moreover, often seem elusive when compared to financial goals. Local leaders may be especially frustrated by sponsor pressure to more clearly identify initiatives (and accompanying measures) that improve mission effectiveness.

Business needs are everchanging and subject to regional and local trends. Moreover, the current health care environment is especially difficult for providers because it requires fast, definitive actions. Once a new system is formed, its leaders should quickly adopt a business agenda that includes:

- A clear description of the system's five-year goals, the sequence in which those goals will be sought, and the reasons such goals will be more easily achieved by a system than by individual facilities.
- A decision as to whether the system's business is primarily acute care, community health improvement, home health care, or some combination of services.
- A decision as to which communities the system will serve. In which will it expand? From which will it withdraw?
- Precise guidelines on capital allocation, mission effectiveness, and operating unit performance. These guidelines should define, in numerical terms, acceptable levels of investment in mission relative to variances in financial performance. They should also include methods

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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?

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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 make which decisions is seldom found. All three compete for control.

Such competition is likely to be especially contentious in systems whose local members are skeptical about the value of corporate services, enjoy a tradition that combines financial success with minimal oversight, or lack experience in sharing accountability with other entities. Systems whose characteristic culture involves conflict avoidance and consensus management may find control issues particularly knotty.

Resolution of such issues is made worse by the increasing difficulty that multiregional and national systems have in recruiting members for their boards. This is especially true of mission-driven systems that must ask their board members to give much time, travel long distances, and lend their wisdom and talents—in return for no compensation and little ego gratification—to the governance of a not-for-profit ministry serving multiple geographic markets in a troubled industry. (In contrast, a local facility that has, say, 100 years of history behind it will usually have much less trouble attracting talent and passion to its board.) Because systems need strong boards to help resolve control issues, the recruitment problem is serious.

Perhaps the worst thing about control controversies is that they can distract the system's leaders. In a newly formed system, local facilities will continue to face escalating market challenges. System leaders must, therefore, find a way to both resolve control issues *and* cultivate local markets.

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. □

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