

COOPETITION: THE WAVE OF THE FUTURE

Catholic Healthcare Providers Must Work with Others to Remain Viable

As this decade evolves, the winds of change will have dramatic implications for Catholic-sponsored healthcare organizations. Regardless of how the 104th Congress approaches healthcare reform, the reality of significant change within the healthcare ministry is being witnessed daily. Healthcare organizations are "right sizing," joining networks, merging, and being acquired by or collaborating with traditional rivals. Trustees, sponsors, and institutional managers know that their organizations must consider such changes in order to survive.

Today's national political agenda implies that healthcare costs are out of control. How much more of the gross domestic product can healthcare consume? As the number of uninsured persons grows, the purpose of Catholic-sponsored healthcare becomes very clear: to serve those in need regardless of their ability to pay. This guiding principle sets Catholic healthcare apart from those organizations which exist to please stockholders.

MANAGED CARE

Can mission win over margin, or will Catholic-sponsored facilities be unable to compete for managed care contracts because of a commitment to serve the poor? Without universal coverage for all citizens, Catholic hospitals may be identified as higher in cost and therefore unacceptable to managed care insurance plans.

This potential dilemma is likely to occur in most markets served by Catholic healthcare institutions. The inherent desire to serve the poor is now being questioned, as "survival of the fittest" becomes the real bottom line. The easy answer would be to abandon one's mission, but we know that is not the correct response during these tumultuous times. Doing so would require sacrificing the ministry's *raison d'être*. Catholic

BY THOMAS A. BARONE



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providers must find creative solutions to survive; otherwise, the number of Catholic-sponsored healthcare facilities will undoubtedly decline.

COMPETITION

Being price competitive while serving the poor is a tough challenge, as difficult as the challenges many religious congregations faced when they established their healthcare institutions. Those sisters had limited resources, enormous faith, and a belief that they were called to serve the needy. Perseverance and hard work demonstrated that their goals were achievable even though they were, in many instances, faced with intense competition.

Such was the case in Zanesville, OH, where the Franciscan Sisters of Christian Charity founded Good Samaritan Medical Center nearly 100 years ago. Throughout the twentieth century, fierce competition with neighboring Bethesda Hospital drove the delivery of healthcare. Realizing that past relationships would no longer work, Good Samaritan Medical Center and Bethesda Hospital have begun collaborating in an effort to better steward resources to meet local needs.

COLLABORATION

The collaborative approach has already produced positive results. For example:

- Jointly operated community trauma and oncology registries began in 1989.
- A joint magnetic resonance imaging program was developed in 1991.
- A jointly owned ambulance began service in August 1994.
- The hospitals currently plan to create a joint regional laboratory.
- The county health department, along with both hospitals, has developed a healthier communities assessment initiative to identify needs of

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citizens throughout the area.

• In conjunction with 130 physicians who serve both hospitals, the two facilities are forming a physician hospital-organization. The hospitals are also creating a complementary management service organization to support physicians' desire to lower overhead costs in preparation for managed care participation.

COOPETITION

These initiatives are geared toward creating an integrated delivery network that allows the missions of both hospitals to be fulfilled. These integration efforts provide a route to maintain a Catholic healthcare presence in central/southeastern Ohio. Some have coined the phrase "coopetition" to describe this new effort, which acknowledges the history of competition while embracing cooperation as the wave of the future. This shift in emphasis has not eliminated competition but rather highlighted the opportunity for institutions to work together to lower the cost of care while improving access.

As a prescription for the remainder of the 1990s, coopetition symbolizes the manner in which Catholic-sponsored healthcare organizations can and will thrive and survive. It is essential that the heritage established by religious congregations continue. By developing new and better relationships with other providers, Catholic sponsors can preserve the opportunity to serve.

RESPONDING TO COMMUNITY NEED

Upholding the mission may not save an institution. Local market conditions will determine the number of providers a community can support and the services they offer. Healthcare reform will help rewrite mission statements to focus on community health instead of institutional survival.

The definition of Catholic-sponsored healthcare need not change, only the application. Success will be measured by how well we respond to community needs—the same standard established when the founding sisters began their healthcare ministry. □

PHYSICIANS, PAYERS, AND POWER

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wanted? Do we want physicians' clinical decision making controlled by non-physicians? Should the incentive to do less (or nothing) control physicians' decisions when there are no outcomes data to direct those decisions? Should the availability of physicians to patients be based solely on the ability or willingness of the doctor to discount? Just how inconvenient should we make it for physicians, or payers, to put the patient first? It is curious that—insofar as I have been able to learn—few of those policymakers and payers who advocate plans with tight capitated payments and stringent utilization controls belong to such plans themselves.

Yes, too often physicians have seemed to put their own incomes first—and the devil take the hindmost, even if the hindmost includes their own patients. Most have rejected salaried practice, which may well be the only sane solution to their current dilemma. They have alienated many of us. But is their clinical autonomy too high a price to pay for our vengeance?

Perhaps it is. Certainly, many physicians think so—even those who could make a handsome profit by undertreating patients whose insurance is capitated. Many policymakers think so as well, even those who have not been historically known as friends of doctors.

Sen. Paul Wellstone, D-MN, certainly the most liberal member of the U.S. Senate, in the last session sponsored the AMA's Patient Protection Act, which limits HMOs' ability to control physician contracting and practice. The "any willing provider" legislation being considered in at least 20 states requires managed care plans to contract with any provider who agrees to abide by the plan's payment rules. This is often a desperate attempt by physicians and other providers to avoid being shut out of contracts. (But what does that say about providers' willingness to stand up to unacceptable contract demands?)

Physicians in Alaska, California, and other states are warming to proposals for single-payer systems; even if such systems threaten lower payment rates, these physicians say, they would allow them and their patients the kind of freedom they feel they are losing. This may be the dawn of the strangest of bedfellows, as liberals who worry about access, quality of care, and profiteering team up with conservative physicians who see in managed care and selective contracts the potential doom of their profession.

This is bare-knuckles power politics, as payers (many of whom were once controlled by providers) seek to make physicians dance to their tune, and physicians seek to reclaim ground long lost. It is an economic battle, to be sure; but it is also a moral battle.

There are strong values on both sides, and great sins as well. But there is also a middle ground, which is where we will likely want to end up. That middle ground must be defined by physicians, government, outcomes researchers, patients, and payers together, in the interest of efficient, effective, affordable healthcare. Sadly, I fear that by the time we get to that middle ground, the path to it will be soaked in blood. □

The author would also like to congratulate Health Progress on 75 years of contributions to healthcare.

NOTES

1. Charles Rosenberg, *The Care of Strangers*, Basic Books, New York City, 1987; Rosemary Stevens, *In Sickness and in Wealth*, Basic Books, New York City, 1989; Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1982.
2. Rosenberg.
3. Rufus Rorem, *A Quest for Certainty*, Health Administration Press, Ann Arbor, MI, 1982.
4. Northwestern National Life Insurance Co., *Employee Benefits in the Year 2000*, Minneapolis, 1989.