Integrated Delivery Systems: Six Tough Questions

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Healthcare leaders have vigorously pursued two interrelated objectives: formation of integrated delivery systems (IDSs) and promotion of healthy communities. Corporate visionary and strategic activities that do not emphasize these objectives are considered anemic efforts, as shown by the increasing number of mergers and acquisitions[1] and the stated goals of the Catholic Health Association and other leading healthcare organizations.

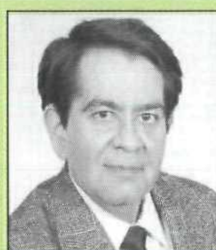
The IDS Trend

The process of forming IDSs often includes establishing a multi-hospital component. At year-end 1995 the 159 most highly integrated systems included 15.2 percent of all nonfederal, acute care hospitals. More than 46 percent of hospital-initiated systems included at least two hospitals. For the most highly developed managed care markets, multi-hospital systems were usually, and continue to be, the rule.

In addition to the hospital and physician components, 11.7 percent of health maintenance organizations (HMOs) were under contract with or otherwise owned by these 159 systems. The plans provided coverage to 12.8 million members, representing 23.3 percent of total HMO enrollment.[2] By 2005 the vast majority of U.S. health resources may be organized and managed by fewer than 850 networks.[3] With more than 60 multihospital Catholic systems across the United States, Catholic providers are eager participants in the merger, acquisition, and consolidation trend.[4]

Nevertheless, a minority of healthcare experts and observers believe that providers' current efforts to organize networks and promote community health will result in massive misuse of resources over time. Catholic healthcare leaders should heed these alternative views as they pursue their organizations' healing mission.

This article addresses six key questions as a framework for exploring Catholic healthcare organizations' goals for expanding their IDSs and promoting healthy communities.



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1. Why Focus on IDSs?

The driving rationale for forming an IDS is to organize and finance a seamless continuum of high-quality care. This design has the potential to coordinate the resources for care delivery to a degree of efficiency and effectiveness not possible with independently positioned provider components.

In the community, an IDS can help mitigate high-risk behaviors and the eventual costly human and financial consequences. An IDS also can promote efforts more likely to effect positive outcomes. Because of its comprehensive but streamlined approach to disease prevention and management, the IDS concept presents an appealing organizational solution to promote community health to 260 million Americans.

However, leaders must consider more practical motives for system formation in light of their immediate task of merging the entities essential to the IDS blueprint. Reasons to pursue a merger may include cost-reducing synergies through improved efficiency and effectiveness, lower salary levels and discount purchasing that result from controlling the region's health resources, concern that free-standing components will not survive, and even some executives' pursuit of power and prestige.[5]

Another reason to achieve this level of consolidation is that bond-rating agencies favor physician and hospital mergers, since these arrangements allow greater leverage in negotiations with managed care plans and other private insurers.

2. Who Wins? Who Loses?

As the reasons for IDS formation interact with a market's particular dynamics, the goals of Catholic healthcare organizations to improve access, reduce operating costs, and enhance quality may not be realized when mergers are consummated. The most successful mergers seem to involve medium-sized, not-for-profit hospitals in the same community. These arrangements depend on creating superior market power in the combined entity; consolidating high fixed-cost services, such as open-heart

Continued on page 78

Continued from page 80

surgery; and, by combining specific service volumes, offering additional clinical programs to the community.[6]

Losers and the Government Unfortunately, few communities remain where such a merger strategy is feasible, where all parties can agree, and where clearance can be obtained from the Department of Justice and the Federal Trade Commission.

Also, the Balanced Budget Act of 1997 included legislation that represents, perhaps unwittingly, a startling distrust of the IDS concept. Beginning on October 1, 1998, Medicare will pay a transfer rate that is lower than standard per-case reimbursement for 10 yet-to-be-named diagnosis-related groups when beneficiaries are discharged early to post-acute care providers. The impetus for paying hospitals a reduced amount grew out of the suspicion that health system holding companies with post-acute care subsidiaries somehow were "double dipping."

Distrust is likely to continue in light of unprecedented interest by the Health and Human Services inspector general in healthcare fraud.

Winners and the Market Smaller hospitals and physician groups, who most urgently may sense their increasing vulnerability to market forces, will seek to be acquired by a major medical center or an IDS. Rather than discontinuing services or even closing, the smaller hospital can then negotiate favorable merger conditions for its community in terms of governance, capital enhancement, and a guarantee of remaining unimpeded as a full-service, acute care, inpatient facility. The health alliance, anxious to protect or expand a tertiary referral base, uses its financial clout to strengthen its market position.

Similarly, physicians will pressure hospitals to acquire their practices. Interestingly, the early management literature confirms these views: "Most mergers are merely a civilized alternative to bankruptcy or to voluntary liquidation that transfers assets from failing to rising firms."[7]

The Patient: Winner or Loser? From the patient or consumer perspective, the health system's willingness to keep existing providers in operation can mean continued access to affordable health services. These benefits will be short-lived, however, if the health network's costs for carrying its investment outweigh the prospects for a reasonable return; the system's mission could be better served by alternative investments; or the community could still be served, but with a more limited investment (e.g., maintaining a complement of emergency and primary care services rather than inpatient facilities).

3. What Has Experience Shown?

An examination of the short-term effects of hospital mergers from 1982 to 1989 shows that the most noticeable change was improved operating efficiency, as measured by increased occupancy and a curtailed rise of total expenses per adjusted admission.[8] These merged facilities were less successful in generating more admissions or reducing their total personnel or nursing staff. The 92 mergers studied showed a slowing of adverse trends rather than dramatic improvements in operations.

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When-and-How Issues The modest short-term impact of these mergers varied. Mergers consummated after the introduction of the Medicare prospective payment system (PPS) and those between similar-sized hospitals displayed greater positive changes in operating patterns than mergers occurring earlier or those between facilities with dissimilar bed sizes. These findings were attributed to PPS-induced cost pressures and greater opportunities for efficiencies in mergers involving similar-sized facilities.

Many mergers yield disappointing results because leaders do not sufficiently study how the potential partners' operations can be integrated to achieve maximum efficiency. The management team also should identify what cultural, strategic, and management problems might interfere with the newly merged organization's goals and objectives.

The Monopoly Factor The inevitable concentration of hospitals, physician practices, and insurers resulting from mergers and consolidations raises an important concern. The market forces that once compelled these components to join forces could dramatically wane in the new order. As a result, the public interest would no longer be served by requiring providers to compete.

In the near future, elimination of weakest competitors could easily culminate in a single network or a few networks dominating each region's health services by geographically and clinically segmenting the market into virtual monopolies (i.e., oligopolies). Huge provider systems then could exercise regional dominance to further their own self-interests rather than achieving such social objectives as expanding access.

An analysis of 122 mergers between 1986 and 1994 found that those in more concentrated market areas (i.e., tending toward a more monopolistic position) had merger-related cost savings (-2.7 percent) that were less than half those of mergers in less concentrated market areas (-7.3 percent).[9] Mergers in more "monopolistic" market areas had a slight price increase (+1.4 percent) instead of a decrease, suggesting that the cost savings and consumer benefits from hospital mergers in more concentrated markets are either marginal or negative and regional health systems functioning as oligopolies may require more antitrust constraints. Interestingly, cost savings were greater in mergers involving hospitals with these characteristics: low occupancy, nonteaching, nonsystem, and not-for-profit.

A second study focused on facilities forming local strategic hospital alliances and concluded that

these networks are being designed to keep competition out and prices high.[10] Patients paid an average $140 more per stay at an alliance hospital than at a freestanding facility.

4. Should Healthy Communities Be the Main Focus?

The development of IDSs fosters the healthcare ideal of keeping people healthy rather than merely treating their diseases. Indeed, futurists have challenged providers to change or augment their organizations' prevailing function. In practical terms this involves inclusion of an insurance component in an IDS whereby the IDS saves money by not admitting patients or performing expensive tests. In the future, IDSs may make significant long-term investments to promote healthy lifestyles, justified by cost-benefit analyses. However, with many merger deals failing to meet performance objectives, many question whether such a radical shift to health promotion and disease prevention will be accomplished in the near future. Companies have collapsed under the weight of too many good ideas, all being pursued at once.

Because HMOs have a stake in disease prevention, they should expend additional resources in this direction. However, acquiring an HMO to change harmful behaviors may distract providers from their most important objective: healing sick patients.

5. Do Some Goals Need Attention?

Most hospitals could improve their clinical care and financial functions. Although serious efforts are underway to reduce inefficient variation from optimal treatment protocols, much work still needs to be done to implement clinical pathway theory most effectively. Providers must also prevent rigid protocols from stifling positive innovation.

In a related area, nosocomial (hospital-acquired) disease remains prevalent in U.S. hospitals. One study showed that adverse drug events, per large teaching hospital, cost an average $5.6 million per year,[11] $2.8 millon of which was associated with preventable cases.

Hospitals' financial management can also be improved. Leaders should analyze the relationship between charges and costs. Some view charges as a meaningless relic from the cost-plus payment era, but more hospitals are reexamining this issue. One hospital reports the following benefits[12]:

- With the number of charges decreased by 80 percent to 85 percent, employees spend less time on the charging function making the charging function more consistent.
- Written policies and in-service programs have improved charge capture.
- Fewer individual charges can better reflect resource utilization.

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6. What Is the IDS Prognosis?

Healthcare organizations eventually may divest unprofitable subsidiaries of their IDSs currently in development. Also, state governments may determine the need to regulate oligopolistic networks, as they do public utilities. Alternately, large IDSs may survive without many internal difficulties or government interference.

Ultimately, however, success will depend on the individual patient. Whether a building across town or in the next state bears the same corporate logo is of little importance to the patient. Similarly, Catholic healthcare providers will be more concerned about their ability to meet community healthcare needs than being part of a powerful network.

Our plea, then, is for Catholic healthcare leaders to continue to ask basic questions: Why are we doing this? Who will it benefit? Are our merger goals sound? What has the past shown us? Are there alternatives?

The communities served by Catholic providers deserve such deliberation and a courageous response. □

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