Health System Changes In the Absence of National Reform

BY JANE H. WHITE

When Senate Majority Leader George Mitchell, D-ME, pulled the plug on the healthcare reform debate September 26, it marked the end of a long, contentious, expensive legislative battle—for now. Many analysts in Washington, DC, believe this debate is far from over. However, politics and the need to return home to campaign for midterm elections have won out in the near term.

The continuing pressures on the U.S. healthcare system will keep healthcare reform simmering close to the front burner. "Rising costs, adverse selection, cost shifting, and the growing number of uninsured Americans will force legislative action in the not too distant future," predicted William J. Cox, vice president of government services, Catholic Health Association (CHA). If Republicans win the Senate and perhaps the House in November, nothing will happen during the next two years except "a long, bloody political prelude to the next presidential election," he added.

However, just because the feds could not muster any healthcare reforms at the moment does not mean the system is standing still. Indeed, the U.S. healthcare delivery system is changing dramatically in reaction to marketplace pressures. The question is, Where do these market-based reforms lead us? Will they lower costs *and* increase access? Are they equitable and efficient?

This month's column examines some of the pressure points in the current healthcare system and the changes emerging as hospitals, insurers, and physicians form integrated delivery systems to address these market pressures.

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Cost: An Increasing Pressure Point

One of the biggest pressure points that is steadily growing worse is cost. This issue was somehow downplayed in the final months of congressional debate, while the mandates and universal coverage gained prominence. But politicians will only act once big blocks of American voters and powerful special interests—such as business, big and small—believe that costs have careened so far out of control that only governmental intervention will help get the system back on track. For now, business is convinced it can do better than government in controlling its healthcare costs. However, the "cost controls" many businesses achieve today are really just cost shifts, which should ultimately add to the pressure for more comprehensive reform.

The latest national health spending data from the Health Care Financing Administration (HCFA) show that the United States spent $884.2 billion on healthcare in 1993, or 13.9 percent of the gross domestic product (GDP).[1] The HCFA data also show that for the first time since the early 1970s, the federal government's share of the total healthcare bill *rose* between 1991 and 1993. As HCFA researcher Katharine R. Levit and colleagues explained:

> In 1960 private funds . . . paid for three-quarters of all health care. The introduction of Medicare and Medicaid in 1966 transferred a large portion of payments to the public sector. . . . From 1974 through 1990 the share of the nation's health care bill funded through the public sector remained fairly constant at 58-60 percent. Beginning in 1991 and continuing through 1993, the share funded by the private sector dropped again. In 1993, 56 percent of all health care spending came from private sources—the smallest share ever.[2]

This rising federal share of healthcare spending constitutes another potent reason why healthcare reform is destined to return to the federal debate. Medicare costs are growing faster than private-sector healthcare costs. For example, Medicare's hospital tab increased 10.1 percent between 1992 and 1993—3.4 percentage points more than the nation's total spending for hospital care, according to the HCFA data. If Congress and the White House are to have any hope of controlling the federal budget, healthcare spending is one place

they will need to assess.

In addition, new data comparing international healthcare spending trends show that the spending gap between the United States and all other countries is widening.[3] HCFA analysts George J. Schieber (now at the World Bank) and Leslie M. Greenwald and Organization for Economic Cooperation and Development (OECD) analyst Jean-Pierre Poullier report:

> The 1980 U.S. health-to-GDP ratio was almost 30 percent higher than the average for the other five major OECD countries, and U.S. per capita health spending was more than 60 percent higher than the average for these other countries. By 1992 the U.S. health-to-GDP ratio was 60 percent higher than the average ratio for these other countries, while U.S. per capita health spending was more than 90 percent higher.[4]

The researchers conclude:

> Compared with the other major OECD countries, the United States is facing the highest rates of increase in health spending relative to GDP, excess health care inflation, and opportunity costs of foregone consumption and investment outside the health sector. . . . The real question for American decision makers is whether rationality can override politics, as the United States approaches the twenty-first century devoting one-fifth of its economy to an expanding health sector in which inefficiency and inequity abound.[5]

System Changes: The Pressure to Integrate

Even with the current failure of federal healthcare reform, state reforms and private-sector pressures in some local markets are producing rapid changes in the healthcare delivery system (see my articles in October, p. 14, and in November, p. 10). Hospitals are merging, consolidating, and aligning in an effort to achieve what has become almost a Holy Grail of the new healthcare order: the integrated, or organized, delivery system.

Northwestern University professor of organization behavior Stephen M. Shortell and colleagues define an organized delivery system as "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."[6] During the past four years, Shortell et al. have identified several models of integration, characteristics important for successful integration, and barriers to integration.

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Models The most prevalent model of integration is a hospital- or health system–based approach. The advantages of this model in financial, organizational, and leadership resources "can be offset by an overemphasis on acute care, focused on filling hospital beds, which runs counter to the demands of population- and capitation-based delivery models," note Shortell and colleagues.[7] Another model centers around physician groups. The third model is a hybrid hospital/physician-led system.

Characteristics Shortell and colleagues identify four key success factors among the more successful integrated systems: "(1) ability to make the system the right size; (2) ability to conduct relevant population-based health status/needs assessment; (3) ability to assume capitation-based risk for defined populations; and (4) ability to develop new management and governance needs."

Barriers The most critical barrier to integration is the mixed financial incentives that hospitals and other providers receive from insurers, government, and other payers. Shortell et al. argue that "until common economic incentives are created for hospitals, physicians, and others to work together, progress in achieving true clinical integration of care at the local community level will be agonizingly slow." Other barriers include:

> (1) the embryonic development of most clinical information systems; (2) the lack of adequate geographic concentration of facilities; (3) ambiguous roles and responsibilities; (4) an overemphasis on the acute care hospital paradigm; (5) the lack of strategic alignment; (6) the inability to execute the system's strategy; and (7) the inability to "manage" managed care.[8]

An Elusive Number Although many observers cite rapid and "dizzying" amounts of integration and consolidation, it is difficult to pin down precisely how many integrated systems currently exist. In addition, when is a system defined as truly integrated? As Shortell noted in a conversation, "There are a lot of networks and systems in the process of integrating, but whether they are really integrated is a matter of dispute."

Despite the difficulty, Shortell and colleagues take an early stab at estimating the amount of integration taking place in this country:

> Approximately 300 hospital systems belong to the [American Hospital Association's] AHA's Health Systems Section. Many of these appear to have most of the components of an organized or integrated delivery

system. To this we might add the sixty or so large multispecialty group practices such as the Mayo, Ochsner, and Cleveland clinics; selected staff- and group-model health maintenance organizations (HMOs) such as Kaiser Permanente and Group Health Cooperative of Puget Sound; some of the newer networks organized around physician groups such as Mulliken and Friendly Hills groups in Southern California; and insurance companies such as Aetna, Prudential, and Cigna.[9]

The AHA is now making plans to start tracking such systems, according to Shortell. From early in its healthcare reform efforts, CHA has envisioned integrated delivery networks as the way of the future. According to CHA's Cox, "Catholic hospitals feel quite pressured and worried about the future, and all are attempting to position themselves for the managed care/capitation revolution. In some markets Catholic hospitals are very advanced [in integrating]; others are just getting started."

Integration Expands

Although the specter of national health reform was one factor behind the rapid drive to integrate in some markets, Shortell predicts that federal reform's demise will not diminish system integration. "The effects of incremental reform [versus comprehensive reform] on those systems and markets already reasonably far along will continue to accelerate, not slow down," he said in a conversation. What may change is that incremental reform will delay the spread of integrated systems to undeveloped markets, he added.

As U.S. healthcare providers feverishly pursue integration, some analysts question the benefits. Jeff C. Goldsmith, president of Bannockburn, IL–based Health Futures, Inc., wrote recently, "I find it stunning how little hard evidence of economic advantage or market share gain has accrued from system development in healthcare."[10] He continued: "Larger healthcare organizations have not been able to produce care at a lower price, or of demonstrating superior quality, than smaller, less integrated competitors. If anything, larger healthcare organizations have actually displayed dis-economies of both scale and coordination." He cites as problems more management layers, high-priced executives, high dependence on expensive consultants, slower decision making, and executives' inability to relate to physician and nurse providers on the front lines.

Goldsmith believes the central question we need to ask in the mad pursuit of integration is, "How is value created in health services?" He added, "What many healthcare executives really seem to be seeking in integration is to maximize the use of their assets, not reduce the per capita cost of care or improve the health of their communities."

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AHA's James Bentley, senior vice president for policy, also raised this and several other questions that hospitals need to examine as they move toward integration:

- What are the values and ethics of those creating the new healthcare system? Collaboration or domination?
- Will Americans perceive greater value?
- How will we do the kind of integrating that Shortell describes in an era of incremental reform rather than comprehensive reform?
- Can people at the top—the administrators, physicians, and nurses—lead this change, or will new leaders be needed?

The Future of the Hospital

As hospitals struggle with what it means to integrate and to survive in a reforming healthcare system, they will find their roles vastly different. According to Bentley, the new direction of the marketplace "is most threatening for those administrators who love running hospitals. Other people are very farsighted and excited about what's going to happen. The bulk of the people are in the middle, however." Cox also noted that the current market poses "an extremely difficult challenge. Most hospital administrators are not trained to deal with the kinds of pressures we're now facing."

Bentley thinks the key is to get away from thinking of the hospital as a brick-and-mortar institution. "It would be better if we didn't have the word 'hospital' to deal with," he said. "It tends to create an image of a brick building and tends to inhibit creative thinking about the future." Although hospitals will continue to be cost centers, Bentley believes they must embrace a "whole range of healthcare roles" and extend the model beyond the building.

Goldsmith noted that some of the most recent and more successful integration has taken place among capitated plans that:

- Do not own hospitals
- Forge relationships with physician groups rather than hire salaried doctors
- Pursue aggressive control of hospital use and cost

"Their principal assets are information systems and cash—not bricks and mortar," he observed.

Goldsmith also cited an emerging model of integration—virtual integration, where organizations are bound together by strong alliances, not ownership. Virtually integrated healthcare organizations are held together and made profitable by

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two elements: "(1) the operating system—that is, the framework of agreements and protocols that governs how patients are cared for, as well as the information systems that monitor that flow, and (2) the framework of incentives that governs how physicians and hospitals are paid," explained Goldsmith.

These trends all pose tremendous challenges to hospitals as they seek to position themselves in the evolving system. In some ways, a comprehensive reform plan such as President Clinton's would have provided a roadmap for healthcare providers and payers as to what was expected, but not necessarily how best to get there. Now that Congress has left reform to the marketplace, any number of directions may emerge, such as integrated delivery systems, only to change as we learn by trial and failure what does and does not work. To survive with such uncertainty, hospitals must be flexible, be forward thinking, and address the critical question of how to provide value, not just fill beds and maintain their institutions. □

NOTES

1. Katharine R. Levit et al., "National Health Spending Trends, 1993," *Health Affairs*, Winter 1994.
2. Levit et al.
3. George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health System Performance in OECD Countries, 1980-1992," *Health Affairs*, Fall 1994, pp. 100-112.
4. Schieber et al.
5. Schieber et al.
6. Stephen M. Shortell et al., "The New World of Managed Care: Creating Organized Delivery Systems," *Health Affairs*, Winter 1994.
7. Shortell et al.
8. Shortell et al.
9. Shortell et al.
10. Jeff C. Goldsmith, "The Illusive Logic of Integration," *Healthcare Forum Journal*, September-October 1994, pp. 27-31.

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Hospitals must now have an internal policy for reviewing suspect transfers.

When the hospital does not own the ambulance, the individual is not "on the hospital property" until the ambulance is on the property.

An individual in a non-hospital-owned ambulance that is off the hospital's property however is *not* considered to have come to the emergency department, even if the ambulance staff contacts the hospital. In those situations, a hospital may deny access if it is in a "diversionary status," that is, lacking the staff or facilities to accept any additional emergency patients. The regulations, however, authorize the ambulance staff to disregard the hospital's instructions and deliver the patient to the hospital notwithstanding the denial. In such cases hospitals will legally be required to provide the screening examination and stabilizing follow-up care regardless of their situation at the time.

Defining Labor

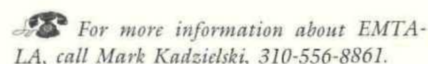
One of the more troubling aspects of EMTALA has been the requirement to provide stabilizing treatment and care to pregnant women having contractions. The 1989 amendments to EMTALA deleted the definition and concept of "active labor" from the statute. The new regulations add a seemingly unnecessary definition of "labor." The purpose of this addition is unclear and suggests that HCFA might be intending to revert to the previous provisions of the law, which left little to a physician's discretion in cases involving pregnant women. If so, this is a development that hospitals must monitor carefully.

Physician Exclusion

EMTALA provides for the exclusion of physicians from the Medicare program for "gross and flagrant" violations of EMTALA. The regulations clarify that a gross and flagrant violation "is one that presents an imminent danger to the health, safety or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high-risk situation." This provision provides a welcome detail to a statutory term ("gross or flagrant") that was vague and appeared to leave excessive discretion to government regulators.

Policy Reviews

As with previous EMTALA amendments, all U.S. hospitals, as well as emergency department physicians and other physicians who see patients in the emergency department, should carefully review their internal policies regarding patient transfers in light of the new regulations. For example, hospitals must now have an internal policy for reviewing suspect transfers and reporting them to the authorities when indicated, since failure to report an inappropriate transfer can now potentially result in a Medicare decertification action. □



For more information about EMTALA, call Mark Kadzielski, 310-556-8861.