System Integration: The View from the Front

BY JANE HIEBERT-WHITE

Hospitals and healthcare organizations are seeking to integrate themselves into healthcare systems with an almost frantic urgency these days. "Integrated delivery systems are hospitals' last ditch effort to survive," explained Mark Weaver, MD, a healthcare analyst for the online financial forum *The Motley Fool*. "The one [hospital] who doesn't get picked into the network is dead," Weaver warned at a December briefing for the health and financial press in New York City.

In view of such warnings, it is no wonder that so many hospital leaders are talking about integration. For example, at the National Convocation of Catholic healthcare leaders in October, more than 170 representatives of the Church's health ministry launched what they call the *New Covenant* process. The delegates formed 16 "strategy action groups" to assess various cosponsorship arrangements and other modes of integration, and to pursue them where they seem promising (see *Health Progress*, January-February 1996, pp. 16-17).

This column reports the views of persons on the front lines of integration—health policy analysts and leaders of not-for-profit hospitals and systems, including some from California, where the pace of organizational change is the swiftest in the nation.

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Market Principles

As healthcare leaders try to navigate the changing marketplace, several overarching principles emerge.

It's Wild Out There Today's healthcare market is brutal, chaotic, and confusing. According to Daniel Bourque, who heads the Voluntary Hospital Association's (VHA's) Washington, DC, office, "It's more like *Jurassic Park* now, with dinosaurs running around trying to act like carnivores and others hiding as herbivores. It's wild out there, [with the] move to increase and aggregate market share and market power." Bourque shared his observations at a November 9 meeting in Washington on "The New Competition: Dynamics Shaping the Health Care Market."

Gail Warden, chief executive officer of Michigan's Henry Ford Health System, a not-for-profit leader in system integration, agreed that "you have to be pretty nimble to stay in the ballgame. There's no loyalty in this business from employers or purchasers" anymore.

And if you think it's brutal now, just wait. With the current low hospital occupancy rates, "enormous profits will be made by those willing to squeeze capacity," predicted Molly Coye, former chief operating officer of the not-for-profit Good Samaritan Health System in San Jose, CA. "The current market will flush out a lot [of excess capacity] that the political system couldn't deal with" in failed national and local health reform efforts, Coye suggested at a September meeting of public health officials in Seattle.

Good Samaritan was recently sold to the for-profit Columbia/HCA Healthcare Corporation. "To make Good Samaritan profitable, analysts expect Columbia to close two of Good Samaritan's three hospitals or convert them into outpatient facilities, cutting duplicate services and cutting staff," report Stanford economist Alain C. Enthoven and his colleague Sara J. Singer.[1]

Healthcare Is Local What is happening in one part of the country may or may not be relevant to healthcare markets in other regions. While managed care and system integration are well developed in California, other regions—especially largely rural ones—are only beginning to feel the effects of market change. Although some areas are still isolated from managed care, "it's coming," said Bourque. "The pace is quickening, and we'll see an acceleration" when Medicare launches reforms that promote managed care.

"For Americans, all healthcare, like politics, is local. People want a face to associate with their healthcare," said Mark Smith, MD, an executive vice president of the Kaiser Family Foundation, at the December press briefing. People like the commitment of local systems to the community

and fear that systems based outside the region will show less commitment, he said.

As hospitals seek to integrate, they would do well to focus on areas where they show regional strength. Catholic systems are pursuing this strategy in California and parts of the Midwest.

Hospital systems are becoming major players in some local markets precisely because of their commitment to the community, according to James C. Robinson, a health economist at the University of California at Berkeley, and Larry P. Casalino, MD, a health analyst. Robinson and Casalino say that physician organizations seeking vertical integration have two main sources of capital:

- Outside, investor-owned physician management companies (such as PhyCor, Caremark, and MedPartners)
- Local hospital systems

"From the perspective of the medical group, these outside investors are attractive because of their lack of encumbrance with hospital beds, yet are disturbing because of their lack of local community commitment and their strict subordination to the equity markets," they said. "Many medical groups prefer a homegrown integrated system to one made on Wall Street."[2]

Healthcare Is Not Hospital Centered "Healthcare is an ambulatory business today," said Veterans Administration (VA) Medical Director Kenneth Kizer at a November lecture in Washington, DC, sponsored by the VA Management Decision and Research Center. Kizer said that hospital leaders need to understand that "we're in the business of healthcare, not hospital care, which has profound implications when you operationalize it." He cited the experience of railroads as a warning: "The railroads thought they were in the railroad business, not the transportation business. As a consequence, they went out of business." Kizer predicted that "the hospital of the twenty-first century will be a very different entity."

Indeed, Robinson and Casalino note that since "managed care aims to shift the locus of medicine away from the acute inpatient facility, organizing a delivery system around the hospital has a less compelling logic with each passing year."[3] Hospitals need to rethink their role in an ambulatory environment, the analysts say.

Value Is Still Valued Kizer said value is a "fundamental core issue today in healthcare." Measuring and promoting high-quality healthcare will be key for successful health systems, he said. Financial analyst Geoffrey Harris of Smith Barney, Inc., agreed that the current marketplace does care about quality. "If there is no quality, there will be no appeal in the marketplace and the numbers won't go up," Harris told reporters at the December briefing. "The marketplace rewards companies that do well" with access to low-cost capital, which in turn enables them to be flexible, he said. Also, some analysts predict that employers' and consumers' desire for more information about the quality of health plans may push the plans to compete in quality as well as in price.

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Collaboration Is Needed to Provide Safety Net Some leaders fear that the push to integrate and gain market share will accentuate gaps in the healthcare safety net for the uninsured. Providers and payers need to collaborate, said VHA's Bourque, "to tackle some of these health status questions and uncompensated care. [Providers and payers need to] recognize a broader obligation beyond the [people] they have to enroll."

Other analysts believe that sharpened market competition will force the American people and the health sphere to support the government's role in providing a safety net. However, given the resounding defeat of national health reform and the continued antigovernment sentiment among voters, this strategy may be wishful thinking at this point.

Lessons from California

With its mature managed care markets and proliferation of integrated systems, California may be a bellwether of what is to come in healthcare for the rest of the nation (though some areas may never reach California's level of organizational change).

If the healthcare market nationwide is "wild," in California it is brutal. "California is the roughest part of country competitively," said Coye. A glimpse of the numbers reveals the state's tough market. According to Enthoven and Singer, the data show "the beginning of a lower cost structure" in California."[4]

Beds in California hospitals declined from 83,644 in 1990 to 79,353 in 1994 and are predicted to fall to 68,800 by 2000 and to 59,300 by 2005, according to a new report from the California Healthcare Association.[5] Hospital bed occupancy dropped from 51.6 percent in 1990 to 44.9 percent in 1994 and is predicted to slide to 42.5 percent by 2000. The California Healthcare Association predicts that more than 80 percent of the state's hospitals will join an integrated delivery network or multihospital system in the next decade, and that the majority of these will develop or join physician-hospital organizations. Some 50 or more hospitals could close, convert to ambulatory acute care use, or be consolidated by 2000.

The California Healthcare Association does predict a continued role for an integrated Catholic network in the state. "Four to seven provider net-

works will dominate California's metropolitan areas by the year 2000—Kaiser, the Catholic network, non-Catholic nonprofits, a for-profit network, public networks, and various combinations thereof," the association's report said.

Virtual Versus Vertical Integration So what lessons does California have to offer hospitals around the country? Robinson remarked at the November meeting: "We've had too much chaos and pain in California to be a model. [However,] the rest of the country can learn from our mistakes. The California experience says: Put doctors with doctors; put hospitals with hospitals; put insurers with insurers. Let everybody contract with everyone else." In other words, the long-touted model of "vertical" integration—where different parts of the health sphere are linked under an "ownership umbrella"—is being passed over in favor of "virtual" integration, or linkage via contract.

Robinson and Casalino analyzed the pros and cons of vertical versus virtual integration. A key advantage of virtual integration is its ability to reward efficient performance. On the other hand, vertically integrated systems with a unified ownership have a greater "potential for coordinated adaptation to changing environmental circumstances," Robinson and Catalina said. These systems have "a single mission statement, a single hierarchy of authority, and a single bottom line," the researchers noted. Yet certain problems can also be seen in vertically integrated systems:

- They tend to substitute bureaucratic structures for entrepreneurial thinking.
- They tend to encourage internal struggles for control of the system's resources.

Robinson and Casalino observed: "If vertical integration worked in practice the way it works in principle, then markets and contracts would be rare." But California has shown an increasing propensity for contracts and virtual integration, thereby contradicting conventional wisdom concerning the benefits of vertical integration.

The Integration Continuum

While many systems in California are pursuing contracting and moving away from ownership, the levels of integration achieved vary widely. For example, payer-provider vertical integration can range from contracting (with various levels of risk), to plan-provider joint ventures, to plan ownership of providers, to provider ownership of local and regional plan subsidiaries. A provider-driven model of vertical integration may develop its health plan either by means of a joint venture or through a wholly owned subsidiary, according to an analysis by Peter Grant, a healthcare lawyer with Davis Wright Tremaine in San Francisco and Seattle.[6]

Grant describes the range of hospital-physician affiliation models (from less integrated to more integrated) as:

- Traditional hospital–medical staff relationship
- Hospital-based service bureau
- Hospital-affiliated independent practice association
- Physician-hospital organization
- Hospital-based management services organization
- Hospital-based clinic model
- Hospital employment of physicians

Finally, as Catholic providers sort out what levels and types of integration make the most sense in each local situation, system leaders would do well to bear in mind some key attributes of a successful integrated delivery system, as defined by a leader who has forged ahead in this brave new world (see **Box**).

"You can get there by different strategies, [but] if you have these characteristics, you have a better chance of being successful," Warden said. □

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KEYS TO SUCCESSFUL INTEGRATION

According to Gail Warden, CEO of Henry Ford Health System, a successfully integrated system will:

- Be regionally organized and delivered
- Be a true economic partnership among physicians, hospitals and health systems, and purchasers, with shared risks and incentives
- Link care delivery and financing to encourage cost-effective use of services
- Offer a predominance of primary and preventive care (80 percent of what the Henry Ford Health System does is in a primary care setting)
- Reduce fragmentation and redundancy of services
- Offer a comprehensive continuum of health services across settings and levels of care
- Offer clinically integrated, outcome-focused care
- Use its resources to satisfy the needs and maintain the health and well-being of a defined population

NOTES

1. Alain C. Enthoven and Sara J. Singer, "Managed Competition and California's Health Care Economy," *Health Affairs*, Spring 1996.
2. James C. Robinson and Larry P. Casalino, "Organizational Transformation under Managed Care," *Health Affairs*, Spring 1996.
3. Robinson and Casalino.
4. Enthoven and Singer.
5. California Healthcare Association, *California Health Care 1996 to 2005: A View of the Future*, January 1996.
6. Peter Grant, *Health Care Restructuring 1995: Horizontal Consolidation; Virtual and Vertical Integration; Innovative Models and Case Studies*, Davis Wright Tremaine, San Francisco, November 2, 1995.