Aligning IDNs' Financial Interests With Communities' Best Interests

BY ANN NEALE, PhD

Americans anticipate that healthcare reform will bring significant, needed change in the way healthcare is organized, financed, and delivered. Catholic healthcare providers envision integrated delivery networks (IDNs) as self-contained systems of providers offering a full continuum of coordinated services to a defined population. We recognize it is important to design the U.S. healthcare system to serve communities and individuals well. However, Catholic healthcare providers believe the *primary* objective of reform is to ensure that the system better responds to community needs.

This article focuses on healthcare managers' responsibility for minimizing the conflict between the financial interests of managers and care givers in a network and the best interests of those they serve. It uses the process developed by the Catholic Health Association's Task Force on Healthcare Management Ethics to help healthcare executives analyze and address the ethical dimension of the issues they face. (For a description of the process, see Sr. Joanne Lappetito, RSM, "CHA Task Force Helps Managers Make Values-based Decisions," *Health Progress*, September 1993, pp. 14-15.)

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Understanding the Issue

Healthcare's unsustainable costs have brought reform to the top of the nation's agenda. To a considerable degree, other issues, such as community orientation, quality, and resource allocation, take second place to financial targets and concerns about margin in the current system.

Virtually everyone agrees that cost containment is necessary. To this end, therefore, healthcare is moving away from external, purchaser-imposed financial constraints, to capitation—a method of reimbursement that puts individual and institutional care givers at financial risk. No longer will providers be paid for each encounter. They will have a defined, limited budget (i.e., the capitation rate multiplied by the number of enrollees) within which they will have to manage each beneficiary's healthcare needs.

Capitation not only has the advantage of effecting the needed economic discipline by radically changing financial incentives. It also has the potential for modifying attitudes and practices that (1) assume that benefiting the patient means providing all treatment, no matter how marginally beneficial, and (2) prize individual good over the common good.

In assuming risk for capitated payments, IDN managers will undertake new arrangements with physicians, hospitals, nursing homes, home care agencies, hospices, and other care givers and agencies. The challenge for the manager of such a network will be to create an appropriate distribution and volume of services and to avoid costly duplication and overcapacity. A balance will have to be established among preventive, primary, acute, chronic, rehabilitative, and other services. Each costly service available to the community and each costly diagnostic or therapeutic modality provided a patient are taken directly out of the bottom line in a capitated system. Healthcare managers must anticipate and avoid everyone's worst fear about possible negative implications of the new era in healthcare—that they will not receive necessary, high-quality services.

In a capitated system, communities and individuals are particularly vulnerable because care givers' and healthcare facilities' interests are aligned, at least potentially, against the communities and individuals they purport to serve.

Identifying the Dilemma

For IDNs to manage successfully under capitated reimbursement, care givers will have to practice with what Edmund Pellegrino has called "diagnostic elegance and therapeutic parsimony." Theoretically, capitation provides the incentive to ensure that patients receive precisely and only the services they need. Practically, because of the realignment of financial incentives, capitation poses a conflict of interest for care givers and

healthcare facilities that are financially at risk for providing care within the capitated budget.

The risk inherent in capitation could induce IDN managers to avoid expensive services and high-risk populations or to craft financial incentives that lead care givers to undertreat persons in an attempt to save money. Care givers could, of course, on their own initiative, adopt such practices.

Ethical problems IDN managers must be prepared to face are already surfacing during this transition. Anecdotal evidence shows that some managed care physicians are subordinating patient well-being to their own economic interests. For instance, to keep their "economic profile" attractive to insurers and managed care companies, some physicians are allegedly "discouraging" resource-intensive, high-cost chronically ill patients from remaining in their care by using such tactics as lengthy waiting times or brusque and rude communication styles. Another cause for concern is contention between primary care and specialist physicians about who should order a patient's costly care (e.g., a magnetic resonance imaging scan).

Determining the Most Important Value

IDNs require new relationships between administrators and care givers to improve the coordination, efficiency, and quality of care. To ensure that providers maintain their professional and fiduciary commitment to communities and patients, it is imperative that IDN managers recognize and avoid the "underside" of the incentive in capitation, which is to withhold necessary resources for patient care in an effort to contain costs.

The threat to the fiduciary ethic contained in capitation is not an idle one. As noted, cost containment is perhaps the prime reason healthcare is undergoing such fundamental change. Furthermore, the professional ethos of medicine has been seriously eroded in the recent past by commercial and entrepreneurial motives and tactics. Finally, organizations have an inevitable self-interest in survival, which could prevail over the objectives of community and patient well-being.

Even though the economic well-being of individual and institutional providers is a value, it must not (and need not) be sought at the expense of another more basic value: the fiduciary ethic of healthcare. That ethic has always meant that healthcare professionals put the well-being of those they serve ahead of their own legitimate self-interest.

The challenge for an IDN manager will be to create an appropriate distribution and volume of services and to avoid costly duplication and overcapacity.

Making a Decision

The management of a capitated system calls for innovation, vigilance, and integrity. To effect genuine healthcare reform, healthcare managers must make a decision in principle to operate out of a community-oriented, patient-focused, high-quality outcome perspective, as opposed to a self-interested, profit-driven perspective.

Healthcare managers who have made such a decision in principle will recruit care givers and select partners on the basis of their community orientation and quality of service, rather than on expedient financial grounds. Their decisions about service lines will be based on community need and quality as opposed to organizational self-interest. Their particular decisions on how to reimburse care givers will be structured so that care giver financial gain does not come at the expense of patient care, but rather is determined on the basis of value to the community and patient and on standards of internal (within the network) equity.

The identification of community need and patient well-being as the primary criterion for healthcare managers' decision making does not minimize the importance of cost containment or financial management. Those objectives should be understood, however, as means to the end of serving communities and individuals well.

Implementing the Decision

The changes that have already occurred provide healthcare managers an unparalleled opportunity to reorder priorities, placing economic values *at the service* of the care needs of communities and individuals. Since meeting a community's needs and ensuring individuals' well-being are IDN managers' primary responsibilities, it is incumbent on them not only to engage care givers with similar values, but also to develop and implement systems and processes that allow them to act on

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At the August 1993 NASHP meeting, Health Care Financing Administration Administrator Bruce Vladeck emphasized his commitment to improving his agency's action on requested waivers. Vladeck, a former New Jersey state health official, spoke of the "need to turn the Medicaid state-federal relationship from a financial one of just writing the checks, to a supportive-assistive, hopefully nonmicromanaged, [relationship] to improve quality and availability of services."

The three states described in this column—Hawaii, Florida, and Washington—represent but the tip of the iceberg in state healthcare reform activity. These three have in common elements of a managed-competition strategy that could provide invaluable insight for the national reform debate, should implementation proceed as envisioned in these states. Other states are pursuing play-or-pay strategies or more incremental reforms, and Vermont is studying a single-payer option. All these efforts will provide us with the critical information required to chart the uneasy course of reform. □

NOTES

1. Allen Dobson, Donald Moran, and Gary Young, "The Role of Federal Waivers in the Health Policy Process," *Health Affairs*, Winter 1992, pp. 72-94.
2. Deane Neubauer, "Hawaii: A Pioneer in Health System Reform," *Health Affairs*, Summer 1993, pp. 31-39.
3. Deborah L. Rogal and W. David Helms, "Tracking States' Efforts to Reform Their Health Systems," *Health Affairs*, Summer 1993, pp. 27-30.
4. Lawrence D. Brown, "Commissions, Clubs, and Consensus: Reform in Florida," *Health Affairs*, Summer 1993, pp. 7-26.
5. Robert A. Crittenden, "Managed Competition and Premium Caps in Washington State," *Health Affairs*, Summer 1993, pp. 82-88.

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Management of a capitated system calls for innovation and vigilance.

those values. This requires, for instance, measuring the network's quality of care and adopting practice guidelines.

Healthcare managers will need extraordinary leadership skills as they forge new, improved relationships with various care givers to ensure, above all, appropriate, high-quality services. This priority of values will not be realized unless healthcare delivery is understood as primarily a social good, a human service, indeed a ministry, rather than primarily a commercial transaction.

When such an understanding and ordering of priorities prevails, the financial arrangements between and among healthcare professionals and organizations, and the patterns of care that result, will be adjudged satisfactory by communities and individuals to whom healthcare professionals are primarily accountable and by care givers who will be assured they can honor their fiduciary responsibilities to their patients.

Understanding and effecting the right relationship among the values of community and patient well-being, quality, and cost containment are imperative to restore and promote the professional ethos of healthcare. Furthermore, conscientious healthcare managers who succeed in this regard should find their integrity rewarded as their networks are selected by many who recognize that the networks' criterion for decision making is the community's best interests. □

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THE CHALLENGE OF A NETWORK

Continuing a network of service providers is a challenge, according to Kathleen Wilber, PhD, an assistant professor in the gerontology school at University of Southern California-Los Angeles, because of a "paradox in terms of how we develop services."

"The major problem with coordination of such a network is that we're trying to do two very different sorts of things," Wilber said. "We're trying to develop a systematic approach to service delivery—something that's predictable, that's organized—but we also need services that are adaptable, flexible, responsive. In developing and coordinating a system, we need to encourage diversity and innovation, and we need to have a lot of different kinds of providers."

Wilber said although everyone always talks about the need to eliminate duplication, flexibility and adaptability are more important because of the complex needs of the elderly being served. She advocates a system of "managed chaos" and pointed to the danger of overrationalization. "It's not a jigsaw puzzle," she said. "There will be some gaps, some overlaps."

By establishing a network, Wilber said, providers often assume they can enable the elderly to avoid nursing home placement. She points out, however, that this attitude views the network as a closed system and puts up barriers to ties with nursing home providers. Providers also often think that coordinated services are more efficient. However, the cost of such efficiency is great, she said. And coordinated services will only benefit consumers if they are also flexible.

"People view case management as the magic pixie dust of coordination," Wilber said. But she views fragmentation of services as a reflection of the complexity of the problems faced by the elderly. "We need some glue to bind us together, but not superglue—so that we don't create a system where no one can move independently and the structure creates problems for us." —*Susan K. Hume*