

## **Integration reconsidered: Five strategies for improved performance**

*Why are financial losses looming so large so quickly? What does it mean for the vaunted IDS model? And what must wholly or partly integrated enterprises do to stabilize and move ahead?*

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The year 1998 has been a terrible one for large complex health enterprises. The year brought well-publicized crashes of former darlings of Wall Street-Columbia/HCA, MedPartners, PhyCor, and Oxford Health Plans. There were also less well publicized financial crises in the nonprofit world -- Chapter 11 bankruptcy for the East Coast's most aggressive "system," Allegheny Health, Education and Research Foundation (AHERF), and unprecedented economic losses for the oldest and largest integrated delivery system in the nation, the Kaiser Permanente Medical Care Plans, which experienced more than \$420 million in operating losses over the past 18 months.

What is particularly glaring about these troubles is that they have occurred against the backdrop of seven straight years of prosperity, job growth, and disappearing budget deficits in the general U.S. economy. What is going on in healthcare? Are the problems large health enterprises are experiencing macroeconomic or systemic to the health industry, and what do they tell us about the dominant corporate paradigm in healthcare-the so-called integrated delivery system (IDS)? And perhaps most important, what can trustees and managers of wholly or partly integrated health, enterprises do to regain firm footing and move their organizations forward?

### **How much can be blamed on economic factors?**

The picture is highly complex, but macroeconomic factors have certainly played a role in damaging the large health enterprise. The most important of these has been deflationary pressure on price and costs in the general economy. Global financial pressure has vanquished inflation. The prices of energy, raw food stuffs, and metals, as well as sophisticated manufactured products like semiconductors, are falling to the point where economists are concerned about whole national economies being undermined. In this environment, it is difficult for anyone in our economy to increase earnings or even revenues by raising prices.

Disinflation in health insurance premiums, and marked deceleration in health costs, has been the dominant macroeconomic trend in healthcare for the past six years. Despite publicity to the contrary, health insurance premium increases remain in the low single digits well into 1998, and the underlying health cost trend is in the 4% to 5% range-double the rate of general inflation, but still a 30-year low.

### **Managed care: The messenger shoots itself and its friends**

It cannot be entirely coincidental that the health cost deceleration took place at precisely the same time as an explosive rearrangement of the structure of private health insurance. Many have made light of this change . . . "What is a PPO, exactly?" Yet the growth in managed care really meant the widespread replacement of open-ended reimbursement for health services, which was inherently inflationary, with negotiated rates and utilization controls, with some degree of risk shifted to providers.

This is an intrinsically more stable and constraining payment framework than the one it replaced. And in the most intense managed care markets, coincident with provider panic, the shift from reimbursement to negotiated rates resulted in significant premium reductions for large accounts-the first per capita revenue shrinkage of the postwar period.

Ironically, disinflation in health insurance premiums has damaged the very health plans that brought it about, and resulted in the worst economic losses in the history of health insurance. The underwriting cycle moved into red ink in 1995, and losses mounted steadily in 1996 and 1997, and rolled forward into 1998. HMOs lost \$1 billion during 1997, and losses are expected to be greater in 1998. Traditional HMO-style health plans with high fixed costs fared the worst; many lost both enrollment and per capita revenue. Group and staff model plans have seen almost 40% of their enrollment disappear since 1989.

But the plans that succumbed to the temptation to grow by merging also were hurt. PacifiCare was damaged by its merger with FHP. United significantly overextended itself with the Metra acquisition. Aetna has had difficulty "incorporating" US Healthcare into its largely indemnity insurance portfolio. And, in a textbook case of "too much, too quickly," Oxford Health far outgrew its financial information systems-losing track of its claims trail and provider payments-and suffered catastrophic losses.

A relatively new industry that grew by leveraging itself off of managed care growth-the physician practice management firms-was also badly damaged, with bankruptcy of FPA Medical Management, significant retrenchment and restructuring and attendant losses at MedPartners, and writedowns by the market leader, PhyCor. These firms played a major role in disinflation in provider payments, by bidding down capitation rates from health plans aggressively in order to build market share and revenues. In doing so, the firms discovered they could not sustain the earnings momentum that Wall Street expected. Investors stripped an industry that began the year with a \$12 billion market capitalization of more than two-thirds of its market value by the end of August.

### **How did providers fare in a disinflationary environment?**

One would assume from the pressure on insurers that provider incomes have been significantly reduced, but that is not the case. In 1997 the hospital industry earned record profits. Indeed, profits have increased every year during the 1990s except one. There were also, with the exception of a single year, continuous gains in average physician income despite a large and growing supply of practitioners. These data obviously conceal great regional variation, but the core franchises that account for more than half of overall health spending are in remarkably good shape economically, given the pressure from payers.

### **Why have corporate entities had so much trouble?**

The problem has been in the corporate enterprises. The dominant organizational paradigm that has guided health system formation in the past decade has been the IDS, which integrates financing and delivery of care, and incorporates to some degree captive physician practices via salaried employment. Kaiser and Henry Ford Health System were exemplars. Many organizations that began as multihospital. systems (like Intermountain Health Care) segued into integration by way of health plan start-ups, and became aggressive purchasers of physician practices.

Teaching hospitals and academic health centers came late to the integration movement, but made up for lost time in the mid- 1990s.

The motivations for IDS formation varied widely. Early IDSs were formed to capitalize on strong local brand identification, and to seek economies of scale and coordination of medical practice. With the prospect of health reform, and a payment system presumed to be turning toward capitation, the IDS was thought to be the ideal vehicle for coordinating care within a fixed budget. Later in the 1990s, the potential for using the IDS to improve the health of enrolled populations and entire communities was an additional motivation.

However, in many cases, the unstated motivation was to achieve hegemony in local markets. Through merger and physician practice acquisitions, healthcare executives sought to leverage against health plans, which were rapidly gaining market presence, in order to preserve their margins and franchises. In some cases, the motive was even balder: to avoid being acquired by a single frightening new healthcare actor, Columbia/HCA. Physician practice acquisition was largely opportunistic and defensive, justified by the looming threat posed by the physician practice management firms, as well as acquisition by local competitors.

Whatever the motivation for IDS formation, idealistic or pragmatic, the present state of the integrated health enterprise is deeply troubled. Only a handful of IDSs are generating decent economic returns, and many have more than equaled their operating profits from hospitals with health plan losses and losses from acquired physician practices. Economic performance has steadily deteriorated in the past two years, and by mid- 1998, some of the best known and most widely publicized hospital-based IDSs underwent unplanned leadership changes. In one case, that of Allegheny Health, Education and Research Foundation in Pennsylvania, the pain and embarrassment of catastrophic economic losses ending in bankruptcy. The largest and most visible health plan-based IDS, Kaiser, continues floundering economically despite significant market share gains. Catholic Healthcare West and Henry Ford Health System saw their debt downgraded by Moody's due to deteriorating financial performance.

Not to suggest that there have not been success stories -- Intermountain Health Care in the West, and Sentara and INOVA in the East are three prominent examples. But in all of these cases, the IDS was built on and financed by an impressive pre-existing local hospital pre-eminence or near-monopoly. In a very large number of other instances, such as Sutter (which began in Sacramento), the Sisters of St. Joseph of Orange, or UniHealth in metropolitan Los Angeles, the economic base for system formation was quite narrow-one or two profitable hospital franchises whose net income helped finance acquisition of other hospitals and diversification into other health-related businesses.

Using the laser vision afforded by hindsight, it's clear several factors have contributed to IDS losses. For one thing, many of the acquisition and carrying costs of larger, more complex systems were assumed to be covered either by market share gains that did not materialize, or by higher payment rates presumably made possible by increased leverage with health plans. However, the health plans consolidated even faster than providers did, and successfully resisted payment increases.

Competitive factors also played a role in damaging IDS operating performance. Competitive bidding among systems and between systems and physician practice management companies drove the price of acquiring physician practices skyward. At the same time, the market value of

physician time purchased by health plans was falling. Systems allocated overhead from corporate offices on top of these sky-high acquisition prices, and saw physician productivity decline by as much as 30% to 40% in the first year after acquisition.

The result was two sets of operating losses: staggering losses on operations for "captive" (who was captive of whom?) physician practices and significant losses on the capitated contracts for which the captive physicians were viewed as essential. Red ink on capitation contracts doomed the Good Samaritan system in San Jose, which collapsed in 1996 and was acquired by Columbia/HCA, and contributed to weakening finances at BJC in St. Louis, AHERF in Pennsylvania, and UniHealth in Los Angeles. For those provider systems that entered the health plan market, bad timing relative to the health insurance underwriting cycle also played a role. As mentioned earlier, health insurance entered negative underwriting cash flow in late 1995 after an almost eight-year run of prosperity. [The underwriting cycle is the result of the disconnect between market-based premium revenues and medical expenses.] As health plans jostled fiercely for market share in the early 1990s, they made rate guarantees that bore little relationship to cost trends, and began paying the price in 1995-96. Some systems, such as Samaritan and Health Partners of Southern Arizona and UniHealth divested their plans rather than face further operating losses and cash calls.

### **The bitter harvest**

But the economic problems that beset the systems pale beside the organizational difficulties. System executives discovered, in the cold light of post-merger morning, that economies of scale were largely a myth—more than equaled by transaction costs and deteriorating productivity and morale. Economies of coordination were nonexistent, as systems experienced slower decision-making and a more politicized decision-making process. These two factors overwhelmed and paralyzed IDS management teams.

But more significantly, as health systems integrated structurally, they disintegrated culturally. The gap between professional and managerial cultures that existed during most of the 1980s and early 1990s widened into a chasm by the late 1990s. Professionals of all stripes -- not merely physicians, but nurses, technicians, social workers, and others—saw their practices increasingly commoditized and marginalized by the growing corporate ethos in their systems; professionals lost contact, physically and spiritually, with the "adminisphere" -- the tiny handful of people running their systems.

These problems have worsened as economic losses forced renegotiation of physician employment contracts, reductions in hospital employment, productivity improvements, or all three. This summer, the deterioration in professional/management relationships culminated in a vote by employed physicians of Medalia, a 300-person multi-site physician group sponsored by two Catholic systems in Seattle, to elect the Service Employees International Union to represent them in collective bargaining with the owner systems. This election sent a shockwave through dozens of organizations struggling to reduce unsustainable losses in their physician divisions. Health system executives are awakening to the reality that whatever else they may have done in system creation, they have created huge physician and health professional bargaining units that are tempting targets for unionization.

### **What to do?**

How can systems regain their footing and improve their operating performance? To do this successfully will require the following:

1. Reconciliation of professional and managerial cultures
2. Continuous clinical quality improvement
3. Agility
4. Transparency
5. Distinctiveness in broad panels

### **Reconciliation of professional and managerial cultures**

Perhaps the single most important task facing health system management is to heal the breach between the professionals who render healthcare, and those who manage the health enterprise. Not merely physicians, but nurses and other health professionals, are increasingly alienated from the corporate healthcare system. Many feel they have no voice in strategic decisions that affect their professional practice and their ability to meet their patients' needs. As non-patient care ventures fall or become less attractive, health executives will be forced to refocus on fostering operational excellence on and off the hospital campus as the principal management task.

There is no magic formula for achieving this reconciliation. Rebuilding trust is a time-consuming, messy, complicated, and agenda-altering task. Professionals must come to believe that their input matters in shaping the strategic direction of the system. And system executives must measure strategic options based on the potential for making a measurable improvement in the lives of physicians, patients, and other caregivers. If those who give and receive care do not notice a tangible, measurable improvement in service and in outcomes, the strategy probably is not worth pursuing.

Many have viewed the physician executive as the solution to bridging the gap between professional and managerial values. However, merely having an MD after one's name does not ensure that one listens to one's colleagues, or takes their concerns into account in making policy. Sometimes, sadly, physician executives are actually less effective listeners to other health professionals than lay managers are. On the other hand, the ability of physician executives to reassure their colleagues that clinical issues are in the forefront of the systems management priorities can assist in creating a climate of renewed collaboration.

The problem with accomplishing this central task is that simplifying the organizations portfolio of services, shedding poorly performing units, and markedly improving efficiency and economic performance (see Agility below) will introduce further tension into an already tense professional environment. Involving key formal and informal leaders of the multiple professional communities in the planning and execution of this simplification is the only way to achieve consensus-and if not buy-in, at least forbearance.

### **Continuous clinical quality improvement**

The substance of the management agenda matters a great deal in re-engaging professionals in the direction of the health enterprise. Indeed, the greatest vulnerability of modern health systems is the large amount of avoidable medical error that occurs within them. As Michael Millenson has recently documented in his book *Demanding Medical Excellence*, the human cost of using our

health system is unacceptably steep. Organizing to reduce avoidable medical error in prescription drug use, IV therapy, infection control, anesthesia, and post-surgical care management will not only save lives but reduce economic risk under health plan contracts.

Organizing to improve clinical quality requires not only good comparative data on clinical performance, but team organization and a peer culture amenable to re-examining and strengthening practice standards. Continuous clinical quality improvement is an integrative process that brings managers and professionals of all stripes together in a common endeavor-improving results and reducing suffering and needless cost. Since everyone who uses the health system benefits from this effort, and since professionals *want* to do a better job, it is hard to deny the importance of the process. Making clinical quality improvement the central management task underscores the importance of effective clinical medicine to the organization and its leadership. Quality improvement, properly managed, can knit fragmented institutions back together.

Mastering the improvement of clinical quality will be important for another reason. Health plans, consumer groups, and health systems themselves will be publishing comparative hospital and health system quality information as it becomes available. The substantial variation in quality (and patient risk) between hospitals and provider systems within a community will become a key differentiator for consumers. Systems with poor results will no longer be able to hide behind a facade of past reputation, "brand identification," or market share advantage. Doing a demonstrably better job clinically is going to make a market share difference in the next decade's healthcare marketplace.

## **Agility**

A major contributor to mediocre financial returns and management problems in integrated health systems has been the doctrine of comprehensiveness-that the IDS must be a completely self-contained and self-sufficient clinical system that geographically covers an entire region. Achieving this comprehensiveness and self-sufficiency has resulted in systems accumulating a large number of poorly performing assets and services-half-empty hospitals, underutilized physician practices, start-up health plans, home care subsidiaries, etc. Health enterprises have become bloated and unresponsive, and are squandering their financial and human capital trying to manage too many diverse businesses.

To be agile means to be a leaner, more focused enterprise where the economic calculus of "make or buy" enters into all organizational decisions. The purpose of agility is to simplify the organization, reduce spans of control, conserve capital, increase accountability for unit economic and quality performance, and significantly increase returns on the organization's scarce capital.

Each function the health system performs-both in service quality and in economic cost and contribution-should be executed at "best of class" levels. Systems can no longer afford to shelter mediocre economic performance in any major task by averaging financial performance across the entire system.

System executives and governing boards must ask themselves a critical question-What do we do better than anyone else?-and focus their capital and management attention on those things. Answering the question about one's corporate capabilities honestly is difficult and painful. But systems must have the governance strength and resolve to take the next step-to "virtualize" their

health enterprise. That is, they must divest, shut down, or take minority ownership interest in the services or businesses they have not mastered; and they must rely upon strategic alliances with suppliers, competitors, health plans, physician practice management firms, and other enterprises, to accomplish what they formerly did with in-house resources.

Exiting businesses that the system has been unable to master and reducing duplicative services or capacity is a painful process, particularly for systems whose past 20 years have seen nothing but steady expansion. Here, too, there is no magic formula, and no defensible dogma. Saying that "no provider systems should operate health plans" denies the reality that some have mastered this business. Similarly, to argue that "no system should own physician practices" denies the reality that some have made this difficult business work. Each system's pattern of competence will probably uniquely reflect its management capacity and track record.

Unfortunately, merely mediocre economic performance is often an insufficient spur for pruning back an unmanageable service portfolio. The sad case of AHERF in Pennsylvania demonstrated that even sustained, catastrophic losses (on the order of \$1 million a day) are sometimes not sufficient to prod a board or management team to cut its losses.

Further, to tell managers and professionals who have spent their entire professional lives trying to be organizationally self-sufficient that they must now work constructively with outsiders to accomplish their goals is profoundly counter-cultural. Powerful antibodies to collaboration with other organizations-particularly with competitors-rise up inside organizations, posing a leadership challenge to those senior managers who are architects of collaborative relationships with other enterprises.

The initial virtual collaborations in healthcare have proven extraordinarily difficult to manage. The Group Health/Virginia Mason virtual collaboration in Seattle has been a disappointment to both parties. While Kaiser has had success in partnering with non-Kaiser hospitals in Portland, collaborations in San Francisco and Los Angeles have been deeply troubled and were scaled back. joint ventures between health plans and integrated systems have struggled all over the country. Virtual collaboration is no panacea; the strategy simply poses a different kind of management challenge. But to be agile, organizations must overcome the political resistance to collaboration, and promote unit managers who can function effectively in a more virtual world.

## **Transparency**

A key to creating a political climate that makes change possible is to end the practice-particularly acute in teaching institutions-of sheltering poorly performing units by averaging their quality and financial contribution information in corporate averages. In these organizations, senior managers are reduced to a kind of hydraulic management, diverting or redirecting vast hidden rivers of cross-subsidy to cover management failure. This management-by-subsidy destroyed the economy of the Soviet Union, as the lack of public, objective performance measures of value (prices determined by market demand, for example) rendered the management process almost completely political.

Teaching institutions have been particularly guilty of management by cross-subsidy, building their economic base on hundreds of secret deals between deans or CEOs and departmental chairs. A recent effort by a teaching hospital CEO to unearth all of the subsidy fund flows produced a chart that resembled the schematic diagram of a Pentium 11 microprocessor.

The breakup of the Soviet Union was brought about by glasnost (or "openness"), a process by which managers and political leaders were held accountable for poor performance. Transparency is glasnost applied to managing complex enterprises. The elimination of indefensible cross-subsidies, and putting each organizational unit, as much as possible, on an each-tub-on-its-own-bottom basis, requires an unprecedented openness of access to performance data, particularly for internal constituencies. Some cross-subsidy is inevitable-particularly in institutions that render a large amount of uncompensated care. But minimizing or eliminating cross-subsidies is an essential task needed to create economic accountability in subunits and spread economic risk as broadly as possible beyond the executive office. Subsidies must be public and publicly justifiable to continue. Unit managers or department heads who cannot become self-sustaining within reasonable time-frames must be replaced.

For health plans, the real variation in cost and quality is not between the plans (which is why the movement of corporate employers toward health plan report cards is going to be disappointing) but within the delivery system itself. Thus, successful plans will become increasingly transparent to the variation in cost and quality in their broad provider panels. Innovative plan design in the next decade will leverage that variation to reward the low-cost/ high-value hospitals, physician groups, and health systems in their provider panels. They can do that by displaying the variation to patients and families so they can make intelligent use of the choice they have demanded, and by varying the cost-sharing so that subscribers who use cost-effective providers bear less of the cost out of pocket.

Providers who offered the best value would get more patients, not because the health plan directed the patients to them via closed panels, but because patients voluntarily chose them. The failure to reward high-value health providers has been the most significant strategic error of health plans. Becoming transparent to cost and quality variation in the delivery system, and providing both information and constructive incentives to patients is the way plans can move from consumer adversaries to advocates.

### **Achieving distinctiveness in broad panels**

One of the big surprises in the health plan marketplace during the 1990s has been the failure of the closed-panel plan to attract subscribers. Plans found themselves unable to reward providers who made economic concessions to be included in closed-panel arrangements. Instead, they found themselves racing to have the broadest, deepest provider panels that maximized consumer choice of physicians and hospitals.

Providers that geared up for selective contracting have found themselves in payment schemes that greatly resemble the 1970s-style Blue Cross plans, with no incentives whatever for subscribers to select them. Thus, the strategic challenge providers face in this environment is how to create customer value that encourages loyal past users of their services to continue, and that tempts nonusers voluntarily to switch.

This is the classic early 1980s marketing challenge in a late 1990s environment, with the key strategic difference being the increasing availability of comparative quality and consumer satisfaction information. Improving clinical and service quality will become a key differentiator between health systems. Mastering continuing clinical quality improvement thus serves a market function as well as an internally integrative one.

What health systems learned in the 1980s "marketing wars" should benefit them now. For example, squandering scarce dollars on image promotion does not generate additional service revenues or volume. Since people really choose physicians rather than "health systems," promoting one's physicians, employed or unemployed, is a good business investment. People do not routinely shop around for specialists; in the main, they often seek to solve focused health problems, many of which are multidisciplinary in nature. Packaging specialists and clinical support around specific clinical issues-diabetes, breast health, back care are three good examples-has proven successful, hence the increased focus on disease management by plans and systems.

Of course, some lessons have not been fully absorbed. It is sad to see health systems squander decades of carefully built up brand equity by renaming flagship hospitals with generic system names like "Excelsior" or "Profundia" and then spending millions of dollars trying to teach consumers the new brands. It is yet to be established that consumers have any interest in "bonding" to health systems. Employers and health plans have been profoundly reluctant to make purchasing decisions based on exclusive contracts with systems, particularly if it costs more.

Thus, focusing on improving clinical and service quality, solving specific health problems for consumers, marketing one's physicians, and creating the highest value/easiest-to-use healthcare services seem to be the most effective ways of being distinctive in broad provider panels.

Healthcare is the most complex product the American economy produces. There is tremendous unleveraged potential in complex health systems, and achieving that potential is going to require abandoning management dogma that has not created measurable value for consumers or employers. Creating agile, responsive, high-morale health enterprises will require a collaborative, open management style, and a willingness to redirect capital, management attention, and energy. Not all systems will survive this transition, but the new health enterprise will be a much better place to work and to receive care.

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