

Can Health Systems Heal Themselves?

Robert I. Field, JD, MPH, PhD

It all seemed to make perfect sense at the time. Combine healthcare providers at all levels of care into a single organization. Strategically place the providers at dispersed locations throughout a region. Make the primary care component as accessible to patients as possible. The result should produce major strides in coordination of care, guarantee strong bargaining leverage with health maintenance organizations (HMOs) and other payers, and allow everyone to prosper under managed care.

This was the vision behind many of the integrated healthcare delivery systems formed in the mid- and late 1990s. The payers had already consolidated into large organizations, often dominating regional markets, so why should the providers not do so as well? Integrated systems could provide them with strength in numbers and at the same time coordinate care to the benefit of patients, review quality and utilization internally to the benefit of physicians, and squeeze out inefficiencies to the benefit of everyone.

Health Systems Laid Waste

Today, many of the integrated delivery systems formed in the 1990s lie on the brink of financial ruin, or beyond. Some are dissolving back into their original components as fast as they can—the smaller you are, the easier to fit into a lifeboat. They have had no leverage with payers, no coordination of care, no enhanced efficiency. What went wrong?

For physicians, a more immediate question also arises—where does the demise of integrated systems leave them? Many who joined systems looked forward to relatively secure futures as employees. A large portion of their salaries were guaranteed, administrative burdens were taken over by centralized managements, and payer contracting was left to managed care experts. Like birds raised in captivity, can they now learn to fend for themselves in the complex business world of healthcare?

For many physicians who remained independent of systems, the same question applies. Large provider-based systems have successfully challenged the bargaining power of HMOs in some but not all markets, so the evolving dynamics of healthcare markets, which seemed clear a few years ago, are now much less certain. Many physicians fear market chaos may result, and it will benefit neither their financial security nor the overall environment for clinical care.

Where Did Health Systems Go Wrong?

Where did the vision of health systems go wrong? To a large extent, it did not. Many of the ideas behind these systems are as valid today as when they were being formed. It is just that the environment changed in unexpected ways. Over the long term, integrated health systems in one form or another may still form the framework for the industry's structure.

How did the environment change? Primarily, this happened in 2 ways. First, many of the large health systems of the 1990s were formed by large hospitals, often teaching institutions. As anyone who has followed American health policy over the past few years is aware, the Balanced Budget Act enacted by Congress in 1997 slashed Medicare reimbursement for hospitals, and particularly hit those with large teaching and indigent care components. The surpluses these hospitals had relied on to fund start-up losses in their health systems suddenly evaporated.

communications, Inc.

From the University of the Sciences in Philadelphia, Philadelphia, PA.

Address correspondence to: Robert I. Field, JD, MPH, PhD, Director of the Graduate Program in Health Policy and Associate Professor of Health Policy, University of the Sciences in Philadelphia, 600 South 43rd Street, Philadelphia, PA 19104. E-mail: r.field@usip.edu.

With no financial cushion, the systems could not survive long enough to learn how to stand on their own operationally.

Second, consumers began to resist the march into managed care. Most large markets never saw the anticipated complete domination of managed care. HMOs grew in importance but never achieved the commanding market share foreseen by some. Fully capitated health plans grew to comprise 50% of many markets, but not much more. Many consumers, apparently, remained willing to pay higher premiums for plans permitting more choice of providers. While many of these plans, including preferred provider organizations and point-of-service plans, are managed to some extent, they do not represent the full HMO model of capitated payments and limited provider choice.

Why did this inhibit the growth of health systems? Because many of the newer integrated health systems only make sense under capitation. They were designed for reimbursement under "global" capitation arrangements in which all levels of care are covered by a single capitation amount, not just the primary care component. With a global payment for each patient in hand, the systems can decide on their own how to divide payments among all of their provider members. These systems essentially function as the funnels for payments from HMOs to physicians and can structure compensation arrangements to promote system-wide goals, such as coordination of care and appropriate utilization of services. In contrast, when each component in the system bills on its own for each service rendered, less opportunity exists for centralized oversight and the system becomes a more disjointed association of providers.

A market that is half capitated and half fee-for-service insurance is the worst of all possible worlds for health systems. The systems' operations have to be efficient under both arrangements, which is an almost impossible task. With healthcare reimbursement, you cannot be in 2 places at once, at least you cannot prosper in both. The once clear strategic direction turned out to be a great circle.

What Is a Physician to Do?

Where does this leave physicians? Actually, they are not in that bad a position. On the one hand, solo and small group practice will be increasingly difficult to maintain. The demands of dealing with managed care and with traditional insurance require ever-growing resources small practices will find increasingly difficult to obtain. On the other hand,

larger group practices, both single entities and associations of independent practitioners (IPAs), can still address important needs. Hospitals and health systems need them because these organizations can no longer afford to employ their own physicians. HMOs need them because the size of an HMO's provider network determines its attractiveness to consumers. And, of course, patients need them, and often prefer them to health system-based practices, which may not be as conveniently located in communities. Moreover, by pooling resources in larger groups, physicians will be more able to afford the computer systems and personnel increasingly demanded by healthcare business.

Many health systems are looking to nurture larger physician groups. Systems are spinning off employed practices, while leaving them with sufficient resources to become strong independent affiliates. Some systems are seeking looser affiliation arrangements with practices that remained independent all along, especially those of specialists. Physicians who expect to receive the financial guarantees and amenities health systems originally promised are sure to be disappointed. More modest relationships, however, may still be possible.

Independent physician practices have another advantage—they avoided the baggage weighing down health systems. The draconian reimbursement cuts of the Balanced Budget Act hit hospitals, not them. The stunted growth of capitation blunted the vision of health systems, but has less of an effect on more nimble physician offices. Physicians who are dissatisfied with the uncertainties facing their practices can find some comfort; at least they are not dealing with the even greater range of business challenges facing hospitals.

The Vision of Health Systems—Updated

In the end, health systems are not likely to go away. They have an important role to play as healthcare grows in complexity. In particular, care still needs to be coordinated, a task increasingly accomplished through sophisticated information systems that no single provider can implement, or even afford, on his or her own. Electronic medical records, disease management protocols, and automated prescribing are just a few of the computer enhancements becoming central to medical practice. Providers at different levels of care will have to figure out a way to integrate their operations to use these new and powerful tools, whether in health systems or in something very much like them.

Ultimately, a new role for health systems will depend on the structure of healthcare reimbursement. Clearly, this will take a different course than it has. Fee-for-service reimbursement has become too costly and HMOs too restrictive for many beneficiaries. New approaches, bringing increased complexity to the organization of healthcare finance, will demand corresponding sophistication in the organization of healthcare delivery, which integrated systems can provide.

One possible new reimbursement approach receiving growing attention is “defined contribution plans.” Under them, employers provide employees with funding to purchase services directly from preselected panels of providers rather than with actual insurance. Another emerging

approach is the use of creative financial risk sharing among employers, insurers, providers, and patients. Under both mechanisms, patients gain access to providers through the providers’ participation in larger networks. This presents a potentially key role for health systems in creating and maintaining provider networks and in facilitating the efficient coordination of care.

The healthcare integration vision of the 1990s, in other words, was not wrong. Coordination of providers in a managed care or alternative reimbursement environment is likely to remain a basic need for the healthcare market, and it represents a structure that can benefit all concerned. The vision is still there, we just will reach it in a different way than originally expected.