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Context And Catalysts For Change In Health Care Markets

by Patricia Lichiello and Carolyn W. Madden

Abstract: Understanding the nature of change in health care markets involves recognizing that not all communities are alike, and hence not all health care markets look or act the same. In a study of fifteen communities sponsored by The Robert Wood Johnson Foundation, the characteristics and culture of each community interacted with market conditions to influence the magnitude, direction, and sustainability of health system change. A catalyst attuned to a market’s context can ignite change, giving the market focus and direction. Recognizing the importance of context to the process of change enhances our ability to understand the consequences of proposed market activities.

Change is a universal tenet of the health care marketplace today; however, the conditions and catalysts for change depend greatly on local market characteristics. The character or culture of a community has many components, including cultural or ethnic groups with particular needs or traditions, age and racial makeup of the population, types and sizes of employers, and the presence of influential religious institutions. Character also can include less easily defined common perceptions, beliefs, and goals. The focus and direction of change also can be influenced by the actions of a market catalyst. The critical component of such a catalyst’s success is its market- or context-specificity. Thus, just as community context differs among markets, what catalyzes change also will differ.

This paper describes the market context and catalysts observed in fifteen communities that were participants in The Robert Wood Johnson Foundation’s (RWJF’s) Community Snapshots study, part of RWJF’s larger Health Tracking initiative. The Community Snapshots study was designed to capture a glimpse of health system change at a particular point in time in different communities across the country.¹

In each market interviews were conducted with hospitals, providers, insurers and health plans, employers, and employees. Participants were asked two questions, posed at different points during a single interview, that were designed to elicit the context in which change was occurring. The first asked what forces had driven the most significant changes in the local market in the past year. The second asked what major challenges or pressures the respondent’s organization had faced during this time.

An analogy for change. A forest fire is a helpful analogy for understanding the conditions necessary for change to occur and persist in a health care market. The size, path, and intensity of a such a fire depend on the conditions of the forest, the actions of a fire starter, and the presence of sufficient fuel to sustain and direct the blaze. What kind of vegetation

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makes up the forest? Are its trees healthy or diseased? What external factors have influenced the forest’s makeup—low rainfall, harsh winters? These conditions are the fuel that allows a fire to be initiated and sustained. If such fuel is sufficient, a single spark or small flame can turn into a massive fire that consumes the forest. If fuel is not sufficient, the spark might ignite only a small, isolated fire that quickly burns itself out.

The Community Snapshots study suggests that change in a health care market operates in much the same way. Pressure for change accumulates over time as a result of forces acting within and on the market. This fuel building sets the stage for a catalytic event to occur. The impact of such an event—that is, whether it ignites change throughout the market or burns itself out relatively quickly—depends on whether there is sufficient fuel in the market: If all sectors are satisfied with the status quo, there will be no fuel for lasting change.

**Contribution Of External And Internal Forces**

The Community Snapshots study found that many of the forces influencing health system change are remarkably similar across markets, regardless of their size or location. Respondents from nearly all of the study sites indicated, for example, that external forces such as the debate over the Clinton health plan and the movement to Medicaid managed care contributed to change in their markets. State-level public policy, such as hospital deregulation and legislation creating defined health plan entities, also was frequently identified as an external market pressure. State-level politics, too—in particular, a transition in many statehouses to Republican majorities—influenced change in many of the markets.

Respondents often described internal pressures that were common across several of the markets, such as excess hospital bed capacity. Many also described internal forces and challenges that were unique to their market and that reflected the character of their communities. These internal conditions—or fuel—appear to have played a far greater role than external forces did in the timing of change within the Snapshot markets, the sector from which change emerged, and the speed and intensity of change.

**Community character.** The demographics of a community, the role of religious institutions in its social and business culture, and the importance of tradition and long-standing social and power structures contribute to a community’s character. Demographic characteristics appear to have influenced the nature of change within several of the Snapshot markets. Between 1980 and 1990, for example, a 45 percent increase in the population of a sixteen-county region in north central Florida brought financial strength to rural hospitals, allowing them to successfully weather recent
changes in hospital payment brought on by increased competition among health plans. In Fargo, North Dakota/west central Minnesota an aging and declining population has forced local hospitals and physicians to align their services and cut costs to compete for a shrinking patient base. In south Florida the clinica tradition of the large Cuban American community—a history of Cuban physicians organizing into prepaid clinics—provides a foundation for this community’s acceptance of managed care plans and capitated payments. Also, the growing ethnic diversity in Orange County from both legal and illegal immigration is altering the dynamics of the region’s health care market: Not-for-profit health care providers that offer services to low-income, uninsured persons are beginning to feel economic and political pressures to cease providing care to undocumented aliens.

The presence of religious-based, not-for-profit hospitals in a community also contributed to the nature of change within many of the Snapshot markets. When hospitals in Indianapolis began to seek alliances with one another, for example, the Catholic-owned hospitals would not ally with the Methodist-owned hospital. These hospitals began to aggressively parse the market they once amiably shared, forcing purchasers and consumers to choose uncomfortable and unwanted allegiances. Conversely, the two hospitals affiliated with Columbia, South Carolina’s largest religious denominations—Catholic and Baptist—began in the mid-1990s to develop collaborative programs with one another to protect, complement, and enhance the market share of each. In St. Louis, where Catholic hospitals have played a major role in the health care market, a recent alliance of hospitals representing four other religious denominations—Baptist, Jewish, Christian, and Methodist—has created a huge unified and competitive presence in the market. The Catholic hospitals responded by consolidating into two separate networks within six months of the merger. Still, all three of the hospital systems make use of a program developed by the Catholic Church—the Neighborhood Lay Health Worker Program of Catholic Community Services—that trains local residents to find and help at-risk persons to gain access to needed health services.

Aspects of the “personalities” of several of the communities appear to have provided the bounds within which change in their health care market was acceptable. In Columbia and Indianapolis, for example, market players see their community as resistant to outsiders. They suggest that this characteristic had significant influence on the reasoning behind, and acceptance of, recent changes in both markets’ hospital sectors. Community traditions also can direct whether and how change is initiated. St. Louis, for example, is a community with a conservative culture anchored by religious denominations. Civic Progress, a group composed of the heads of the region’s largest businesses, is a historically dominant player in the city’s power
structure. Study respondents suggested that little can be accomplished in St. Louis without the input of this group.

**Market characteristics.** Market conditions such as an excess of beds, too much duplication of services, and high costs in the hospital sector have contributed to the nature and direction of change in many markets. Experience with managed care also has influenced change within some markets. Because managed care typically means restrictions on choice and referral to specialty care, it can meet with more resistance in communities with a long history of indemnity coverage, such as Des Moines, and little experience with managed care. In Des Moines actions by one large employer, John Deere, to push employees into managed care had little effect on the market: Unemployment is low, and the market has a large number of “headquarters employees” who are accustomed to generous indemnity benefit packages and who were reluctant to accept benefit changes. Yet the presence of dominant employers, such as DuPont in Wilmington, Delaware, has influenced some health care markets, as have the health benefit purchasing strategies of large public employers.

Change in some of the Snapshot markets also has been influenced by the culture and tradition of the market’s health care providers, both physicians and hospitals. In Indianapolis, for example, a proposed merger of the market’s single academic health center (AHC) with a large private, religiously affiliated hospital will affect substantial numbers of physicians and allied medical personnel. At the time of our study, merger negotiations were bogged down partly because it was not clear what would happen to the AHC’s traditional modes of clinical practice, teaching, and research.

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**Actions Of Catalysts In Initiating Change**

The Community Snapshots study suggests that a discrete catalytic event can ignite markets in which external and internal pressures have built up over time and created a momentum toward change. Alternatively, markets can experience interactive, though less focused, change on many fronts as the result of concurrent actions by players in several sectors.

Although they were not asked to identify catalysts of change (or even leaders of change), respondents in many of the Snapshot markets were quick to point to a single person or event that had ignited changes in their market. Catalysts are temporal by nature, and it is important to emphasize that the design of the study purposefully captured the look of these markets at a single point in time. Our discussion of catalysts focuses only on those that respondents identified as having acted during the past year or two.

A catalyst’s role in effecting change also is limited—a catalyst is not the “cause” in a cause-and-effect relationship. Rather, causes are catalyzed into
effects. Catalysts in the Snapshot markets have emerged from nearly all market sectors: providers, insurers, health plans, purchasers, and consumers. Based on our review, we have identified five types of catalysts in these markets: individuals, institutions, private purchasers, public purchasers, and the power of fear.

**Individuals as catalysts.** The actions of individuals within two Snapshot markets have initiated a wave of change across both. In St. Louis the 1993 merger of Barnes and Jewish Hospitals (already a merged entity) with Christian Health Systems, creating the BJC Health System, sent shock waves across the health care market. The merger has been characterized as a blockbuster event—and a jolt to competing hospitals—that has had ripple effects throughout all market sectors. The merger was a direct consequence of the actions of Christian Health Systems’ president and chief executive officer (CEO), Fred Brown, who proposed to bring his system to the Barnes and Jewish merger as a third partner and to structure and lead the newly merged entity. He was consistently mentioned as a catalyst.3

In Indianapolis a dominant hospital’s new CEO, William J. Loveday, hired from a health care system in Long Beach, California, brought with him his vision of the future for health care systems and a mission to lead his new hospital into it. According to several respondents, he was the first health care administrator to “preach networks” to his peers in Indianapolis. He redirected his hospital’s market strategies, created hospital and provider networks, developed and marketed managed care products, and restructured the relationship between his hospital and its affiliated physicians. As they began to take effect in the market, these actions catalyzed a wave of change across Indianapolis’s provider and insurer/health plan sectors.

The example of St. Louis (and later in this paper, of Boston) raises the question of whether markets respond to individuals as catalysts or to the institutions they lead. For the Snapshot markets, a distinction between the two was made by market participants themselves. They pointed to the single entity or action that they felt had defined and directed change in their market. Because we did not ask for this information, it seems valid to allow respondents’ identification of the catalyst to speak for itself.

St. Louis and Indianapolis illustrate the importance of community context in influencing change in a health care market. Change likely would have occurred in St. Louis without the BJC merger, as several pressures were at work: an excess of hospital beds and declining patient days, increasingly aggressive private- and public-sector purchasers, and an ever more frayed safety net for low-income, uninsured persons. Thus, sufficient fuel was in place for change to occur. The BJC merger, which responded to these pressures and played to the community’s strong tradition of religious affiliations within the consumer population, induced the type, direction, and
speed of change that the market is experiencing now.

In Indianapolis internal pressure for health system restructuring had not been substantial. Respondents suggested that Loveday was successful in getting change to take hold in this market in part because he tapped into an important aspect of the community’s character: Hoosier pride and an associated resistance to “outside” interference. The key to his success was persistent reminders to peers that they should not let “what happened to the banks” in Indianapolis happen to the health care market; that is, they should not allow regionally or nationally based entities to purchase and run their local businesses. Instead, they should make whatever changes are necessary to succeed on their own.

**Institutions as catalysts.** The Community Snapshots study illustrates that the actions of institutions can catalyze change in a health care market. According to respondents in Boston, for example, the market was ignited in 1993 by an alliance between the two largest of the market’s five AHCs: Harvard affiliates Massachusetts General Hospital and Brigham and Women’s Hospital. In a market that was shaped and defined by these five entities, the alliance between two of them was a destabilizing event. It led to a “feeding frenzy” of merger negotiations and network development among providers, with repercussions across all other market sectors. The remaining three AHCs began to seek mergers or affiliations that could position them as full-service networks, and hospitals across the market began to consolidate services, restructure their relationships with physicians, and downsize their administrative staffs. Both hospitals and health plans also started courting community health centers to bolster referral bases and compete for Medicaid managed care clients.

Internal and external pressures had been building for a long time in Boston, so dominated by its AHCs. The market had a significant oversupply of hospital beds and specialists, very high service costs, and an increasing rate of managed care enrollment and was experiencing a post-recession shift to an economic base of small, entrepreneurial firms seeking a choice of insurance products. State implementation of several public policy initiatives over the past five years, including recent legislation to repeal both hospital rate regulation and some provisions of comprehensive reform, also was pressuring the market for substantial change. These pressures combined to create a market ready for a catalyst to give focus and direction to change.

**Private purchasers as catalysts.** Pressure from large, private purchasers fueled change in several of the Snapshot markets, but respondents in San Diego and Wilmington identified these purchasers not as fuel but as catalysts directing change in their markets during the study window. In San Diego premium negotiations that took place outside of the market between
three statewide employer purchasing coalitions and statewide health maintenance organizations (HMOs) led area employers to expect that their premiums would decline by similar amounts. Their expectations forced health plans to lower their premium rates to local employers and in turn reduce their payment rates to providers. In response, delivery systems were forced to cut costs (including containing primary care physician salaries) and began consolidating to capture market share.

In Wilmington, where the local economy is dominated by DuPont, the health care market caught fire when the company moved aggressively in 1993 to create point-of-service and closed-panel managed care options for its employees, along with incentives for employees to choose these options. The decision sent shock waves through the provider and consumer communities that reverberated across the insurer/health plan, provider, and employer purchaser sectors of the market. Because DuPont so dominates Wilmington’s health care market, if it has a change of heart regarding the structure of its health care benefits, this change might yet again catalyze another shift in the health care market.

Public purchasers as catalysts. Public purchasers have fueled change in nearly all of the Snapshot markets. In Portland/Vancouver, however, respondents suggested that the state as a purchaser was catalyzing, not fueling, the market at the time of the Snapshots study. Both Oregon and Washington had recently initiated new purchasing programs for low-income persons—the Oregon Health Plan and Washington’s Medicaid Healthy Options program and Basic Health Plan (a state-subsidized program for the working poor). These programs brought large numbers of new enrollees into managed care plans, which accelerated consolidation among health plans and providers throughout the market. The state initiatives emerged as temporary catalysts to boost and redirect change in a market that has been in a continuous state of evolution since the early 1980s.

Fear as a catalyst. Fear of losing market share, of losing position in the market, or of being forced to do business in a way that is contrary to historical visions or traditions can be powerful fuel for change. In Fargo/west central Minnesota the effects of a declining and aging population base, an oversupply of hospital beds, and reduced lengths-of-stay all created financial troubles for providers. A new pressure emerged when market participants became concerned that “market-hungry” health plans in the oversaturated Twin Cities market were targeting their market as a referral base and scouting within it for new provider affiliations. This added threat catalyzed participants into more aggressive action to preserve their market. Rather than letting the market dissipate and turning over control of the patient base to outside insurers, health plans, and provider networks, local hospitals and physicians initiated mergers, alliances, networks, and group
practices to consolidate their strength.

**Market Change In The Absence Of Catalysts**

Catalysts in the Community Snapshots study focused the energy of change in their markets and provided it with direction. Markets without such a catalyst—that is, where none was identified by study respondents—seemed instead to be experiencing change that lacked continuity and direction. Participants in these markets acted out of uncertainty, continually responding in a variety of ways to a variety of stimuli within and on the market.

According to respondents, Orange County has such a health care market. The market is in a state of disjointed change, with no leadership from any sector and no clear direction. Respondents suggested that the market reflects a local cast of mind that favors decentralization. During the study window, change was occurring in several sectors—particularly in the health plan and provider sectors—with little organization or consolidation within or across them. Premium negotiations between statewide purchasing coalitions and statewide health plans that catalyzed change in the San Diego market contributed to competition among health plans in Orange County but did not catalyze market change. Respondents predicted that this discontinuous change would continue for several years.

The south Florida market also was in a period of intense, discontinuous change during the study window. Insurers and health plans were bargaining for lower prices, hospitals and physicians were consolidating, and employers were pushing the market toward managed care. Yet none of these actions was catalyzing the market, giving it focus and direction. Government, through generous federal Medicare adjusted average per capita cost (AAPCC) rates, generous state Medicaid capitation rates, and state licensing exemptions for Medicaid-only health plans, had been the most recent catalyst, just prior to the study period. These policies inflamed existing competition among aggressive for-profit health plans and providers in this market, which has a large elderly population and a growing economy.

**Conclusion**

The Community Snapshots study underscores the fact that not all communities are alike, and hence not all health care markets are at the same point in their development or even on the same development continuum. By recognizing the importance of local community context to the process of change, we enhance our ability to understand the consequences of private business decisions and public policy initiatives. The economics of a health
care market interact with individual community characteristics, such as the presence of cultural or ethnic groups with particular needs or traditions (south Florida and Orange County), a population base undergoing transformation (north central Florida and Fargo/west central Minnesota), or the existence of an influential business sector (St. Louis), to influence the magnitude, direction, and sustainability of change.

The Snapshots study also reveals that change in a health care market evolves continually as pressures acting within and on a market accumulate, and catalysts emerge from this local context to advance change. Catalysts are a known and manageable risk that focuses change in a market where before there was disordered uncertainty. The evolutionary nature of change in health care markets means that we cannot predict whether the changes captured in our snapshots will be successful or if they will soon burn out. We propose that if the focused, directional changes that were characterized for us in some of the markets are to be sustained over the long term, there must be continued pressure within the markets for change to occur.

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NOTES

3. Also see Hospitals and Health Networks: Pacesetters (October 1995). This is a magazine supplement published by American Hospital Publishing that focuses on the BJC merger and the role of its new CEO.
4. The California Public Employees Retirement System (CalPERS); the Pacific Business Group on Health (PBGH); and The Health Insurance Plan of California (The HIP), a state-sponsored purchasing coalition for employers with between three and fifty employees.