UCSF/Stanford: Building A ‘Prestige Cartel’

A health care strategist comments on the UCSF/Stanford merger strategy and its potential to avoid the pitfalls of integration.

BY JEFF GOLDSMITH

Peter van Etten’s paper provides a thoughtful counterpoint to the conventional wisdom about the future of academic health centers (AHCs). Evidence is mounting that conventional integration strategies have not produced either market leverage or earnings for AHCs. Indeed, they have proven exceptionally costly for some. The collapse of Allegheny Health Education and Research Foundation, which declared Chapter 11 bankruptcy with $1.3 billion in debt during 1998, was a direct result of the miscarriage of such an integration strategy—that is, primary care physician network development and community hospital acquisition built around a bleeding AHC core—at the incompletely merged Medical College of Pennsylvania/Hahnemann/Graduate Health System. Reported major financial losses at the University of Pennsylvania Health System also resulted in major part from network development and the absence of expected leverage in a highly consolidated health plan market. Declining earnings at the BJC Health System in St. Louis also appear to be tied to an AHC-linked integration strategy.

Unfortunately, there is a lot more bad news to come on this front, as the accumulated losses eventually will be counted in the billions of dollars for AHCs alone. The integration strategies were premised upon health plans’ willingness or ability to channel patients to closed-panel health systems. However, plans discovered limited or no employer demand for these products, let alone a willingness to pay more for the privilege of using the “branded” closed system. Rather than reducing costs to users, most AHC integration efforts have attempted to extract higher prices for existing products, without adding value.

IS THIS A FINANCIAL STRATEGY?

Van Etten’s strategy of cautious regional consolidation of tertiary services reflects a more sober and realistic view of the market difficulties that AHCs face and a way to avoid many integration pitfalls. The UCSF/Stanford merger certainly was not proposed to the two faculties or respective boards on the basis of an “economies-of-scale” argument. It was smart not to do so: $20 million in one-time administrative savings on a revenue base of $1.3 billion is budget dust.

Rather, the financial justification for the UCSF/Stanford strategy was to avoid capital and program costs. AHCs and their clinical faculties are unrepentant capital junkies. All too frequently, medical faculty seem to think that funds for capital and programs come from the tooth fairy, rather than being earned by someone. Van Etten is a former AHC and university chief financial officer and has spent most of his career thinking about the returns from AHC capital investments. Conserving capital by avoiding needless duplication of programs and services is a vitally important

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benefit of the UCSF/Stanford strategy.

Such savings would probably not have been achieved by merging the medical schools, a process that would have consumed a decade in divisive politics and set up a “where’s mine” dynamic between the two campuses. The UCSF/Stanford strategy raises the question of whether formerly competing faculties can become collaborators if they are not forced together by the merger of the medical schools themselves. Van Etten’s strategy permits and abets such collaboration, which can only take place when parallel, competing teams begin working as colleagues. The pleasant surprise is that so far it seems to be working.

**MARKET LEVERAGE THROUGH RESEARCH EXCELLENCE**

The carrot for collaboration is access to larger numbers of very sick patients in an enormous regional catchment area. Larger populations at risk for complex illness will provide major leverage for investigators in all disciplines as they compete for research funding. UCSF Stanford Health Care will be very effectively positioned in highly competitive clinical research arenas.

The unspoken premise of the merger, however, is the ability to translate research preeminence into clinical market leverage, something that no AHC I know of has yet figured out how to do. These are two of the most distinguished clinical faculties in the world and two spectacular biomedical research institutions. Patients know this. Many patients with a choice will want access to these clinical faculties when they are diagnosed with complex medical problems. Their demand could translate, ultimately, into bargaining leverage with health plans, enabling the system to avoid being boxed out of networks and achieving higher payments.

The merger combines not merely the hospitals, but the practice plans of the two institutions. In teaching hospital parlance, it is a “clinical enterprise” merger, enabling single-source contracting across both institutions for hospital and physician services. Although this is a great leap over the traditional, highly fragmented AHC structure, no one, least of all Van Etten, would argue that this system is even close to being able to manage medical risk within a global capitation arrangement. The acid test will be the ability of the clinical enterprise to control medical expenses and improve quality in a heterogeneous payment environment. Leaping into financing care or direct contracting with employers or the Medicare program does not appear on the UCSF/Stanford radar screen.

With 11 percent market share for tertiary services in the Bay Area, no one could credibly argue that UCSF Stanford Health Care is a health services cartel. Moreover, there is a credible tertiary competitor at California Pacific Medical Center, which is a division of a huge regional quasi-integrated system, Sutter Health. What UCSF/Stanford has done is to create a “prestige cartel,” one that should translate, at the margin, into somewhat forgiving payment rates, justified not by charity care or “mission,” but by consumer expectations.

For this leverage to be sustainable, however, patients must actually be treated like customers, rather than serfs, so that they will return if they experience new problems. The challenge here is daunting. Most AHCs are notoriously user-unfriendly, and their clinical care “systems” often sprawl like coral reefs over millions of square feet of poorly designed space. Most AHC faculties are oblivious to customer service issues and may actually perceive the “leverage-the-health-plans” aspect of the strategy as alleviating pressure to be more responsive to patients.

**FUTURE CHALLENGES**

Larger cultural challenges exist in translating research preeminence into noticeable clinical benefits. There is long-standing and bewildering fragmentation of the “knowledge” business in academic medicine. Biomedical science and clinical medicine are interdependent and overlapping enterprises, but the cultures
of these two core “businesses” of AHCs are very different. Bench scientists disdain their clinical counterparts in many medical schools, even where they are housed in the same clinical departments. Even clinical investigators sometimes resist collaboration with colleagues who devote 100 percent of their time to clinical care. It will require a massive culture change to encourage bench scientists and clinical investigators to seek out and drive collaboratively toward clinical application that really matters for patients.

UCSF Stanford Health Care is a world center in basic genetics and cell biology research. The future of medicine lies (somewhere) in this arena. Yet there are daunting steps between possessing critical mass in genetic research and leveraging that knowledge in ways that benefit patients. The likely translational pathway lies in faculty collaboration with biotechnology firms, whose products will not benefit single institutions meaningfully. Places like UCSF/Stanford and the University of Pennsylvania, which have staked their futures on a differentiation strategy based, ultimately, on generating scientific knowledge, will not succeed unless their faculties can more effectively capture the proceeds of scientific discovery and direct them toward better outcomes for their patients. Realistically, this process could take the better part of a generation.

The merger may also result in sensible information technology (IT) investments. The majority of capital spending for academic centers in the next ten years will not be in more buildings but in information technology.

Here too, avoiding duplication, leveraging with hungry IT vendors, and making intelligent choices of IT applications that drive management processes could make a measurable difference and improve both efficiency and customer service. Can UCSF Stanford Health Care make intelligent IT investments that enable both clinical and management processes and that permit UCSF/Stanford to deliver cost-effective, user-friendly tertiary care?

AHCs cannot count on surviving as high-class “welfare cases,” even with a really compelling case. Universities should remove the Medicare teaching cost payments (the mysterious source of those “Medicare profits” that federal health policymakers continuously report) and disproportionate-share hospital (DSH) payments from their AHC operating income; these funds are in every sense soft money. When even liberals such as Sen. Jay Rockefeller (D-WV) publicly doubt whether those subsidies should continue as part of conventional Medicare payment, it is a sign of coming trouble. AHCs are going to have to earn future economic returns in an increasingly unforgiving clinical marketplace.

AHCs are hellishly complex organizations. Peter Drucker has said that they are the most complex organizations in human history. In ten thousand years archeologists will dig them up and say to one another, “What in God’s name lived in here?” Simplifying these organizations—eliminating cross-subsidies and increasing financial and service accountability (or, in contemporary management argot, making them more “transparent”)—is among the most difficult challenges Van Etten and his colleagues face.

In the future managed care marketplace, health plans won’t steer patients. Patients will steer patients. Health plans will provide subscribers with information to help them make intelligent choices and will provide financial rewards such as reduced deductibles or premium costs for doing so. To survive, AHCs must influence consumer choice. To do so, they must create measurable value for consumers and health plans. Thoughtful observers and advocates of AHCs will be watching anxiously to see if the UCSF/Stanford collaboration ultimately pays off for those who receive care.