POLICY FORUM

Trusting in the Future: The Distinct Advantage of Nonprofit HMOs

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HEALTH CARE THAT IS STRUCTURED TO ACCOMMOdate the sensitivities and demands of human biology will look different from health care that is organized to meet the requirements of stockholders and quarterly profits. Structure implies function in the corporate environment as decidedly as it does in the natural world. A health plan constructed for financial profit measures success quarterly. A health plan created to accommodate the needs of human biology, on the other hand, adopts the perspective of a life span; its success is best expressed in health outcomes and quality of life. Members ought to be able to trust that their HMO is primarily focusing on their health. Yet advocates of nonprofit HMOs have not succeeded in calling attention to their differences from for-profit organizations. Most surveys indicate that people do not understand or care about the distinction. One reason is that the not-for profits have done little to translate the relationship of trust that they have established with their members into market advantage, preferring instead to maintain an ivory-tower existence and to refrain from arguing the merits of their status.

Nevertheless, the achievements of managed care in improving the health status of communities can be traced directly to the not-for-

The Milbank Quarterly, Vol. 75, No. 1, 1997
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profits. A hallmark of the work done by Harvard Community Health Plan (HCHP), Group Health Cooperative of Puget Sound (GHCPS), and Kaiser Permanente (KP) during the past 30 years has been their participation in critical public policy debates regarding Medicare and Medicaid, the creation of the Federal Employee Health Benefit Program (FEHBP), the HMO Act, and the recent attempts to reform health care. Moreover, these same organizations have actively explored public policy options through publicly funded research and demonstration projects like Medicare Risk and the social HMO work of the past decade. Earlier on, GHCPS, HCHP, and KP led the examination of ways to bring the poor into the organized mainstream systems.

Nonprofits have been the leaders in building close and productive relations with academic medical centers for the purpose of training future physicians and other health providers; they also have been in the vanguard of health care research. Because they view these activities as part of their public responsibility, the nonprofits have partly funded this research themselves. Although some of the providers remain with the organizations that trained them, thereby constituting a pool of professionals who understand the nonprofit environment, the majority move on. Together, HCHP, GHCPS, and KP train more primary care physicians for practice in the United States than any other organization or academic institution in the country, and they do so with internally generated core community service funding.

Nonprofits have conducted research in disease management, in the design of care, and in the organization and financing of health care; they have contributed their completed and tested findings to the public domain by publishing in the professional and trade literature on topics like multiphasic screening; screening for breast cancer, colorectal cancer, diabetes, and hypertension; care of the elderly and its financing; organization of outpatient surgeries; and normal vaginal delivery after prior cesarean section.

That health—not wealth—is the priority of nonprofits is illustrated by their stand on community rating. Resisting pressures from private purchasers to set prices that reflect their risk pools, nonprofit managed care companies have generally favored rating and underwriting practices that protect the community and spread the risks. Most nonprofit HMOs maintain the premise that the interests of the community are best served when the costs of illness are shared through community rating rather than adjusted for the benefit of employers with the youngest work

forces. Although individual behavior can lead to risks, the interactions between an individual's behavior and his or her health risks are not sufficiently understood to justify financing that penalizes those with poor illness profiles. Despite market pressures that have caused some nonprofits to move slowly, and reluctantly, away from pure community rating practices, most remain committed to the underlying principles of "social" insurance.

Relationships Are the Foundation of Trust

The social mission of nonprofits is also reflected in the people who work for them. Attracted by the opportunity to practice their profession in supportive settings and to work within incentive systems that reward patient care and advocacy, the professionals who have joined the nonprofit integrated health systems are committed to their patients and to a system based on values rather than dictated by the drive for profits.

Health care is at its heart an exchange between people: patient and family on the one hand, professionals and support staff on the other. Good care cannot be delivered without professionals and support staff who are devoted to patient care of superior quality. The not-for-profit integrated systems have been largely successful in creating an environment that fosters these relationships.

The merest suggestion that a plan or a physician is acting in the interests of profit or personal gain, however, can contaminate the relationship with their patients. All capitated or prepaid systems face considerable scrutiny on this issue. Many people assume that decisions on care and coverage are based on opportunities for the physician, the management, or the enterprise itself to gain by withholding care or by providing substandard treatment. For-profit enterprises have faced the same accusations. In fact, these perceptions have been reinforced by jury decisions, anti-managed-care legislative initiatives, and the small, but growing, anecdotal evidence of abuses related to the motives of both nonprofit and for-profit HMOs that is reported in the media.

The argument can be made that the size of the larger nonprofits, their internally directed professional culture, and the amorphous nature of "public" trust allow them to act as if they were accountable only to themselves. At least one feature of the for-profit alternatives—their return to stockholders—has a clear and quantifiable measure. Whereas

accountability to the "public" is often more difficult to define, this difficulty in fact mirrors accurately the uncertainties and variable interests that are integral to the delivery of health care to individuals. One task for the nonprofits will be to communicate more clearly the fact of their patient-, member-, and purchaser-centered accountability in order to translate the advantages of their delivery systems from the realm of theory into a more immediate and visible domain.

Finally, many nonprofits have built partnerships with organized labor. Much of their work force is represented by unions, and many of their members belong to labor trusts. Nonprofits are challenged as never before to modify work rules and to pay for their staffs while maintaining the relations with organized labor that are crucial to their success. This situation represents both a problem and an opportunity. If nonprofits do not develop a constructive partnership with organized labor, they risk eroding, if not destroying, an important potential asset. If, alternatively, they can redirect their partnership with organized labor to the benefit of both union-represented workers and their own organizations, they will have distinguished themselves from their nonrepresented competitors.

People, then, are at the heart of building public trust. Stimulating people's creativity and initiative to work for the interest of patients, members, and purchasers poses a particular challenge.

Quality: A Long-Term Outcome

An organization structured for the long term, whose mission is achieving health, is better equipped to improve the quality of care. Look at the recent, consumer-focused progress in health care: Health Plan Employer Data and Information Set (HEDIS); medical best-practice protocols; and goal setting to improve health status. Nonprofits have led the way in quality improvement.

Have these efforts taken place without regard for cost? Absolutely not. Successful organizations have discovered that delivering superior care is the most effective way to control costs. Leading clinical researchers, like Dartmouth Medical School's John E. Wennberg, Cedars-Sinai's Scott Weingarten, and Duke University's David E. Eddy, base much of their work on the assumption that poor or inconsistent health care is the

primary source of costs in the United States. That assumption is based on three critical factors:

1. Only a fraction of health care practiced in the United States today is based on sound population science.
2. There is an astonishing variation in how physicians practice, which is independent of what is known to work.
3. There is an equally large variation in how organizations are designed to support physicians and other caregivers.

Integrated, nonprofit systems are uniquely positioned to step into the gaps created by these factors. Their competitive success has been the result of a superior ability to control for variation in clinical care.

In an integrated, nonprofit HMO, a web of incentives encourages the most effective care of the patient, in the best setting, by the most appropriate professional. Since their livelihood depends entirely on the success of the overall effort, physicians have a reason to treat patients appropriately and in the most cost-effective manner, starting with prevention, continuing through acute care and rehabilitation, and concluding with services to the dying.

The marriage of medicine and management is a crucial element of the structure that understands and copes with variation. The integrated nonprofit systems have built cooperative ventures that emphasize partnership, sharing, and integration of decision-making and enterprise leadership. The formation of effectively managed groups of committed physicians whose internal structures promote communication, learning, and discipline is a cornerstone of integrated nonprofit systems. Such groups are better able to organize and deliver care consistently in a way that works for patients and enrolled populations.

The incentives and the values of the nonprofit integrated systems have led to the development of considerable knowledge. Since their inception, outcomes studies have been conducted about what works, for whom, under what circumstances, and at what cost. These studies represent a major contribution to the science of health care practice over the 50-year period that many of these organizations have been in existence, most notably HCHP, GHPS, and KP.

Because they have access to huge databases of information that has accrued over many years, they can more easily conduct outcomes re-

search and lower the learning curve of health care workers to achieve the best practice of medicine.

Realizing the Potential

Can nonprofit health care systems translate a quality that is as intangible and value laden as trust into a marketplace advantage? The distinct contributions of nonprofits erode when they are lumped with other "managed care" entities in debates about the appropriateness of care, the treatment of physicians, and core motivations. Faced with the new health care environment, the not-for-profit, integrated HMOs must weigh their capabilities carefully and work creatively to ensure that their values and their commitment to comprehensive care, and to the institutions that deliver it, will thrive in the emerging health care system.

There is ample opportunity to continue in their role of innovator and to build on their 50 years of experience. Nonprofits throughout their history have focused on building the strength and staying power to serve patients, members, purchasers, and communities over the long term. This capability enables them to care for patients over their lifetimes and those of their children. It enables them to invest in their members' long-term well-being and to build lasting relations with employers and communities. These capabilities—these commitments—are undivided and carefully protected. The mission of the nonprofits is to provide service and care. Unlike their for-profit relatives, their success is measured in terms of service and care.

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