Trends and models in physician-hospital organization

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Physicians and hospitals have developed new models for aligning their incentives and integrating their activities. These models serve numerous purposes, including unified contracting with managed care organizations, improved access to capital and patients, and strengthened competitive position. The more advanced models carry the added potential of providing comprehensive, community-based care with less duplication of services. The new models raise several important issues that providers need to consider before embarking on these strategies.

There has been a great deal of interest in physician-hospital relationships over the past few years. Surveys to assess the attitudinal climate, governance involvement, and employment relationship between hospitals and their medical staffs have been conducted by academics, professional societies, and consultants. Most recently, the Prospective Payment Assessment Commission initiated a survey of hospitals’ ability to influence cost-effective practice behavior on the part of their physicians. All these studies focus on internal relationships between a hospital and members of its medical staff.

Competitive economic forces are driving the health care industry to develop new models of physician-hospital relationships, however. These relationships are different in that they are formally organized, contractual, and/or corporate in character and include physicians outside the boundaries of the medical staff. Such relationships are known as physician-hospital organizations (PHOs), management service organizations (MSOs), foundation models, and integrated health organizations (IHOs). These relationships have been described frequently in the medical group management and group practice literatures. With few exceptions, however, the new organizational models have not received much attention in the hospital administration literature.

This article outlines the new competitive forces that are encouraging the formation of these new models from the perspectives of the parties involved: physicians and hospitals. It also describes the competitive strengths and competences of the parties that are harnessed in these new arrangements. The article next describes the structural features of these new organizational models. It concludes with a discussion of the issues and implications that these models pose.

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COMPETITIVE FORCES FOSTERING THE NEW MODELS

Competitive forces facing physicians

The health care marketplace has become an increasingly unfamiliar, uncertain, and unfriendly environment for physicians. Changes in physician reimbursement in both the public and the private sectors and other environmental changes have significantly affected the ability of physicians to set and maintain their own levels of annual income.

Reimbursement under Medicare is increasingly fixed, and the implementation of the Resource-Based Relative Value Schedule (RBRVS) is lowering levels of payment for specialists while raising levels for primary care physicians (PCPs) in relative, but not absolute, terms. Medicaid payments in most states have become so meager as to discourage many physicians from participating in that program at all. Private payers are limiting the ability of physicians to shift the cost of public programs onto the private sector by expanding the use of managed care and other discounted and/or fixed-fee arrangements for their beneficiaries.

Efforts by physicians to make up for reductions in payment per unit of service by increasing the number of units of service provided are being inhibited (and prohibited) in both the public and the private sectors through utilization review and other monitoring programs. Finally, attempts by physicians to tap alternative sources of revenue through the establishment of in-office ancillary services are encouraged by tighter licensing and other regulatory restrictions and by managed care companies that specify in their contracts where such services are to be provided.

At the same time that physicians are experiencing these limitations on their practice revenues, they are also facing increased costs of operating their practices. The costs of medical malpractice insurance, medical supplies, office occupancy, and nonphysician personnel are all increasing at a rate greater than the increase in practice revenues, resulting in a flattening out of professional net income. The net effect of these new economic realities for many physicians is that financial expectations are no longer met and long-term economic security is of increasing importance.

The economics of medical practice is only one source of consternation for today's physicians. The impact of managed care on the practice of medicine itself is perhaps even more important. The physician is no longer the exclusive agent of the patient, determining where the patient should be treated and how much care should be ordered. Instead, the physician is confronted by managed care imperatives such as prior certification for hospital admission and surgery, continued stay review, and case management.

PCPs are being asked to be gatekeepers, that is, to provide care themselves for a broader range of medical conditions and to refer to specialists less and then only when absolutely necessary. Patterns of referral are increasingly dictated by managed care contracts, causing many PCPs to switch from specialists to whom they have historically referred. Some specialists consequently may get fewer referrals and often must seek permission from the gatekeeper or from a utilization management person before performing diagnostic and/or therapeutic procedures or scheduling follow-up visits. Selective contracting arrangements with hospitals may further curtail their autonomy.

Finally, physicians are confronted by increasing administrative complexity (popularly known as the hassle factor) in dealing with multiple plans and insurers, each with its own unique administrative and paperwork requirements. In addition to creating the discomfort that comes with significant change, all these factors contribute to the increased cost of operating a medical practice.

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The forces and stresses described above have special impact on solo practitioners and small groups. Today's practice environment requires more sophisticated systems, including information systems and in-office medical technology, as well as personnel with managed care contracting, marketing, and other more advanced management expertise. Solo and small group practices do not have the financial wherewithal to acquire and maintain these capabilities. They may also lack the capital needed to recruit partners and expand services. Consequently, physicians increasingly favor group practice settings, as gauged by the number of groups (16,500 in 1988), the percentage of active nonfederal physicians within them (one third in 1988), and their increasingly large average size. Of course, the growing size of group practices also