Hospital-Physician Relationships: A Hurdle on the Road to Reform

BY JANE H. WHITE

Throughout the summer, federal plans for healthcare reform continued to stall, to the chagrin of many in the healthcare and policy communities. Even within the Clinton administration, the tension was apparent between the desire to forge ahead and the need to wait for a politically appropriate moment to unveil the health reform plan—after the president's economic package and budget have passed.

Despite delays in Washington, many in the healthcare community believe reform must and will move ahead in the private marketplace and at the state level. Catholic Health Association (CHA) President and Chief Executive Officer John E. Curley, Jr., commented in an interview: "I think health policy reform, especially on the delivery integration front, is going to occur regardless of what happens in Washington."

Reforming healthcare delivery via integrated delivery networks (IDNs) is the centerpiece of CHA's reform strategy. At its annual meeting in June, CHA unveiled a draft of its *Handbook for Planning and Developing Integrated Delivery*, a resource it will release in October to help Catholic facilities push ahead with systemic reform. For CHA, the IDN strategy "is both a necessary antidote to the nation's increasingly dysfunctional delivery system and a way for Catholic healthcare providers to give contemporary expression to their mission, values and ministry."[1]

The American Hospital Association (AHA) supports such integration as well, under the label "community care networks." The managed competition approach favored by President Clinton looks to such networks as the basis of "accountable health plans" (AHPs), which would compete for business channeled through regional health alliances. Several states are forging ahead on this front.

As the healthcare community moves toward integrated delivery networks, a number of significant challenges arise. CHA's handbook cites several: In some areas, managed care is not well established enough to build integrated networks; costs of "retooling" are significant; and legal and regulatory constraints are often formidable.

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Perhaps the biggest obstacle, however, is provider resistance based on tense relationships between physicians and hospital leaders. As Jeff Goldsmith, hospital and physician consultant based in Chicago and national adviser to Ernst & Young, put it: "The hospital/physician relationship is at once rapidly evolving, widely variable from region to region, and extremely unstable. This unstable relationship will significantly constrain the implementation of health care reform."[2] William J. Cox, CHA's vice president for government services, underscored this concern in a conversation: "Anecdotal surveys of our members all indicate that the hospital-physician relationship is the most significant challenge they face." He was quick to add, "However, it is not insurmountable." This column explores the issue of hospital-physician relationships and its potential impact on healthcare reform.

Trends in Hospital-Physician Relationships

A number of studies have documented the historical tensions between hospital leaders and physicians.[3] Questions concerning control over patient base, revenue streams, autonomy in clinical decision making, access to technology, and staffing are but a few of the issues that crop up.

Medicare Financing Several policy observers have pointed to changes in Medicare financing and the growing complexity and competitive nature of the healthcare market over the past decade as culprits in exacerbating hospital-physician tensions. As John K. Iglehart explained in his recent *New England Journal of Medicine* column:

> By establishing fixed hospital payments for particular patient diagnoses [under the prospective payment system], Medicare placed hospitals at greater financial risk for clinical services provided by their medical

staffs; physicians' incentives were left untouched by this scheme. . . . Medicare's new fee schedule for physicians may further complicate the situation because many administrators fear that this payment method will encourage practitioners to shift more patient care to their own offices or to free-standing ambulatory care facilities.[4]

The financial incentives built into Medicare lead to a win-lose situation: If hospitals can get doctors to order fewer tests and procedures under a given diagnosis-related group (DRG), the hospital wins, buy physician income may be lowered and clinical autonomy is challenged. Physicians, on the other hand, may come to rely less on the hospital as the core site for providing healthcare services, and thus divert business away from the hospital.

Changes in the 1980s Beyond the significant changes in Medicare financing, the 1980s brought growth in managed care, multihospital systems, and outpatient services provided at doctors' offices or other freestanding facilities. In the process, the interests of hospital management and physicians increasingly diverged. Goldsmith noted that hospital management during the 1980s "became preoccupied with a new complexity in health services," focusing on such concerns as mergers and joint ventures, regional expansion, new service development, and capital and technology expansion.[5] "Physicians correctly sensed a loss of control over their institutions and a loss of importance. As a result, many hospitals and medical communities actually 'dis-integrated' during the 1980s, sowing the seeds of mistrust and conflict in advance of a decade of reform," he continued.

New Survey Data A new survey by Lawton R. Burns at the University of Arizona, Stephen M. Shortell at Northwestern University, and Ronald M. Anderson at University of California–Los Angeles goes beyond anecdote to offer a more quantitative glimpse of trends in hospital-physician relationships.[6] The researchers surveyed all physicians in Pima County, AZ, in 1985 and 1990 on areas of hospital-physician conflict. Their findings suggest that "the new environment of competition and cost containment [in the 1980s] has exacerbated traditional frictions between physicians and hospitals, rather than generating new ones."

According to the survey, the most pointed physician-hospital conflict arose as a result of concerns about nursing and ancillary staff quality. In 1990, 41 percent of surveyed physicians were concerned with nursing staff quality versus 17 percent in 1985. Conflicts between physicians and hospitals over ancillary staff quality increased from 11 percent to 24 percent over the same period.

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The authors suggest "these traditional problems of quality are most likely exacerbated by cost containment strategies pursued by hospitals (such as downsizing), the shortage of nurses, and the observed difficulties physicians report in obtaining requested equipment."

The area of conflict with the next-largest increase from 1985 to 1990 involved physicians' concerns about control over medical care decisions—up from 13 percent to 24 percent. Other more traditional areas of hospital-physician conflict cited included physicians' limited input in developing hospital policy (cited by 31 percent in 1990 and 32 percent in 1985) and unclear or inconsistent hospital goals (cited by 30 percent and 24 percent, respectively).

The researchers also found that "three of the major strategies that hospitals have employed to increase hospital/physician bonding—governance/managerial involvement, salaried roles, and hospital-based positions—generally fail to reduce conflict in traditional areas between the two parties and may even heighten it." They concluded that "hospitals should thus consider different approaches for tying physicians more closely to the hospital."

Moving toward IDNs

In an interview, Jeff Goldsmith strongly questioned the direction that hospitals are now taking in moving toward integrated delivery or community care networks. "I don't think hospital management has thought through the operational consequences" of such integration, he said. "Hospitals need to think more rigorously about how much risk they want to absorb." The oft-cited examples of Kaiser/Permanente or Mayo Clinic as model integrated networks "took generations of cultural selection," explained Goldsmith, to attract physicians with compatible goals. "It isn't the *structure* that makes these organizations work," but the long-term culture of "people committed to collegial goals."

"One thing becomes clear from studying the small number of existing integrated health enterprises," explains Goldsmith in his *Health Affairs* commentary. "In them the hospital is truly an ancillary service—a capital-hungry, troubled cost center. The hospital is not the appropriate nucleus of an integrated health care system." CHA's Cox reiterated this point in his comments: "Hospitals

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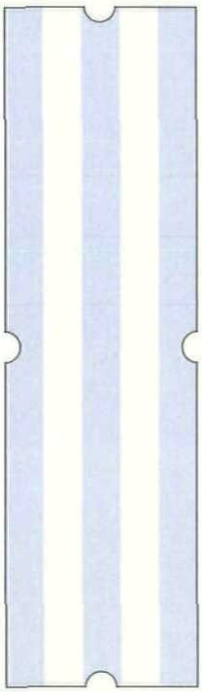

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Without hospitals and physicians working together, a power vacuum emerges.

will become one of many different providers in a continuum of care; the prominence they have today, they are not going to have in the future. Today they are revenue centers; tomorrow, cost centers."

Creating truly effective integrated networks will take "a tremendous sifting and sorting process," said Goldsmith. Such a process will take time. He urges the hospital community to "expand its time horizons by double or triple"—a 10- to 15-year process to create integrated networks. "It may take a generation for the cultural and interpersonal factors that constrain medical practice to align themselves to permit the emergence of truly integrated enterprises," Goldsmith explained.[7]

In the meantime, Goldsmith suggests starting with a focus on integrating primary care services for a community or region rather than full-blown delivery networks with a higher financial risk and chance of failure. Whether hospitals scale back plans for delivery integration or continue with a broader approach, the relationship of hospital and physician will remain a key point in achieving progress. Said CHA's Cox, "We must assure the physician community that they are not going to be working for a hospital, but rather in a joint partnership that will be mutually beneficial." Without hospitals and physicians working together toward integration, a power vacuum emerges. "It comes down to whether we want insurance-based or provider-based systems in the future," said Cox.

With a narrow window of political opportunity for achieving healthcare reform, it is critical that providers work together and repair fences built by years of mistrust. "I think this country is damaged by the guilt and blame" that different provider and health interest groups have lodged against each other for the current health system's failure, said CHA President Curley. "It is time to throw off those old clothes and accept shared responsibility," he concluded. □

NOTES

1. Catholic Health Association and Lewin-VHI, *A Handbook for Planning and Developing Integrated Delivery* (draft), St. Louis, 1993.
2. Jeff Goldsmith, "Hospital/Physician Relationships: A Constraint to Health Reform," *Health Affairs*, Fall 1993.
3. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, New York City, Basic Books, 1989; G. L. Glandon and M. A. Morrisey, "Redefining the Hospital-Physician Relationship under Prospective Payment," *Inquiry*, Summer 1986, pp. 166-175; Lawton R. Burns, Ronald M. Anderson, and Stephen M. Shortell, "The Effects of Hospital Control Strategies on Physician Satisfaction and Hospital-Physician Conflict," *Health Services Research*, vol. 25, no. 3, 1990, pp. 527-560.
4. John K. Iglehart, "The American Health Care System: Community Hospitals," *New England Journal of Medicine*, July 29, 1993, pp. 372-376.
5. Goldsmith.
6. Lawton R. Burns, Ronald M. Andersen, and Stephen M. Shortell, "Trends in Hospital/Physician Relationships," *Health Affairs*, Fall 1993.
7. Goldsmith.