Physician And Health System Integration

Public and private policies push physicians and health systems together, but they can also drive them apart.

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ABSTRACT: Incentives for vertical integration in the health care industry have led many hospitals to consolidate into health systems and profess a desire for closer alignment with affiliated physicians. In this study of fourteen organized delivery systems and their 11,000 physicians in sixty-nine medical groups, we found that many health systems did not align well with physicians. Even systems ostensibly committed to alignment emphasized structural relationships that did not enhance physician-system alignment and paid inadequate attention to issues of importance to physicians. This gap between the goal and reality of physician-system alignment appears to be the result of systems’ responding to a changing mix of policies, not all of which foster integration.

Over the past two decades the movement to create a competitive marketplace in health care combined with developments in financing and the law to produce strong incentives for the various components of the health care delivery system to organize into vertical arrangements. Countervailing forces also came into play, however, so that the perceived value of integration varied from time to time and across different health systems and locations. Vertical integration can be comprehensive, incorporating both insurance and delivery functions into managed care organizations (MCOs), or it can be more limited. Some systems might pursue ownership-based vertical integration, while others might see “virtual integration” through strategic alliances and joint ventures as more promising.

We studied one facet of vertical integration: physician alignment with health systems, or the degree to which physicians and their medical groups share, identify with, and work toward accomplishing goals together with their affiliated health system. In a multiyear study we examined numerous measures of the character and extent of physician alignment with health systems, the factors most...
strongly associated with alignment, and the barriers and facilitators to achieving such alignment. The details and findings of that study are reported elsewhere. Here we describe the study briefly but focus on the implications of our findings for specific public and private policies affecting decisions about health system integration.

**Research design.** This research involved sixty-nine physician organizations associated with fourteen organized delivery systems. The medical groups (primarily organized medical groups as opposed to independent practice associations, or IPAs) ranged in size from 3 to 958, with an average size of 76.4 and a median size of 25.0, and on average were larger and more likely to be multispecialty than were all groups in the United States.

The organized delivery systems, all nonprofits, ranged in size from one to eighty hospitals per system and a median of eleven. They averaged 4.6 affiliated medical groups, with a range from one to twenty-three, and had total revenues in 1998 from $340 million to $6.2 billion, with an average of $2.1 billion. Most were located in single market areas, but several were present in multiple markets. For the most part, they represented some of the largest, most experienced organized delivery systems in the country.

Data are from two sources: (1) surveys of physicians about the medical groups and systems in which they work; and (2) surveys of and interviews with medical directors and other key managerial informants about care management practices, compensation methods, and the management and governance of the medical groups. Physician-level data were aggregated to the group level to obtain measures of group culture and then merged with the data on care management, incentives, and management and governance. Multiple regression was used to examine the study hypotheses pertaining to physicians’ attitudes and behavior.

**Movement Toward Vertical Integration**

A number of public and private policies stimulated vertical integration of physicians and their health systems over the past two decades. Some of these explicitly fostered integration, while others did so indirectly.

**Impact of competition.** Above all, attempts to constrain costs by encouraging competition in health care created strong pressures favoring vertical integration of hospitals and physicians into comprehensive systems, in the hope that they would compete to offer one-stop shopping for a range of inpatient and outpatient specialty services and physicians. Physicians and hospitals at least initially bought into this approach, accepting that they needed to demonstrate a capacity to provide a wide range of medical, hospital, and other services to attract large capitation contracts. Hospitals perceived that they needed to keep their competitors from “buying up” their physicians and squeezing them out of the new market. They also saw physician-system integration as overcoming the inefficiencies of uncoordinated physician practices, as well as providing a source of inpatients.

Physicians, moreover, felt that larger, often hospital-based, networks could negotiate on their behalf with more market clout than they could on their own and that the networks offered a degree of protection against giant, potentially predatory MCOs.

**Pressure from federal law.** Generally paralleling the developing market forces, several federal laws also created strong pressures for individual practitioners and hospitals to combine into vertically integrated systems. David Frankford and others have noted the influence of both antitrust law and federal fraud-and-abuse laws in encouraging vertical integration. Antitrust principles generally preclude either individual hospitals or solo physicians from colluding to increase their bargaining power but permit concerted action when the hospitals and physicians combine into a single entity or at least share substantial financial risk. Fraud-and-abuse laws
have penalized certain compensation arrangements for independent physicians, generally favoring vertical integration and employment, although they provide somewhat complicated limitations on those arrangements.

- **Influence of federal and state programs.** Federal and state programs also promoted health enterprise integration, albeit indirectly and with mixed effects. The Clinton Health Security Act initially created a sense of anticipation of the need to integrate health systems to do business with “accountable health plans,” and several state health reform measures would have had similar effects. The failure of purchasing alliances to develop as a major competitive market force, however, undermined the strength of this factor.

  For much of the past decade and more, states vigorously pursued strategies to move Medicaid enrollees into MCOs. Similarly, passage of the Medicare+Choice (M+C) provisions of the Balanced Budget Act (BBA) of 1997 seemed to signal the impending decline of the individual-patient Medicare market. Although stimulating MCOs to contract for public program enrollees was the direct thrust of these policies, hospitals and physicians anticipated a need to reorganize to do business with those plans. More directly, the BBA provisions authorizing provider-sponsored organizations (PSOs) to take capitation without an intervening health maintenance organization (HMO) briefly boosted interest in hospitals’ and physicians’ joining to create health plans. With Medicare and Medicaid MCOs not expanding and even leaving the programs, momentum has also slowed or even reversed, creating questions about the need for systems to integrate with physicians to retain Medicare and Medicaid revenues.

- **Changes in private-sector financial arrangements.** Another set of factors that changed over time were the financial arrangements in the private sector that seemed to be moving in a direction that strongly favored physician-system integration. In particular, global capitated payment was viewed as a key driver of integration by engendering common financial incentives for hospitals, health systems, and physicians. The seemingly imminent conversion of nearly all third-party payments to capitation created a sense of urgency in aligning physicians and health systems. Global capitation did not spread across the country to the extent that had been anticipated, however, so this factor also greatly modulated in recent years.

- **Improved quality of care.** The latest policy encouraging, or at least capitalizing on, organization of providers into integrated physician-hospital delivery systems is the emerging systems-oriented approach to protecting patients and enhancing quality of care. While improving quality has been a long-standing issue, health plans and organized delivery systems are now seen as far better suited to track and improve quality than individual physician practices or hospitals are. Indeed, the view that shortcomings in patient care are system, rather than practitioner, problems is now gaining favor. Clinically focused care management practices are being developed at many levels, including multi-hospital health systems. Efforts by the business community to improve patient safety, such as the recent Leapfrog initiative of the Business Roundtable, seem likely to increase pressure for strengthening linkages between hospital systems and their physicians to improve systems of care.

- **Countervailing forces.** Not all public and private policies have fostered integration. Countervailing forces also came into play. Integration had to occur against a long-established backdrop of so-called corporate practice of medicine laws, which had prohibited nonphysician corporations from employing physicians. These statutes and legal doctrines remained on the books and eroded gradually as integrated systems evolved.
Some states also made integration into selective, highly aligned entities more difficult with “any-willing-provider” laws that allowed health professionals to participate in a wide range of loosely aligned networks that cut across health systems. In the context of these multiple and shifting public and private policies, to what extent did health systems successfully pursue alignment with their physicians? Our study measured the degree to which health system activities actually affected indicators of physician alignment, particularly physicians’ attitudes toward the system and their behavior with respect to health system objectives.

Indicators Of Physician–Health System Alignment

Organizational and financial ties. Many hospital systems did choose to pursue vertical integration by creating financial and structural linkages with physician practices. Hospitals sought to consolidate physicians in independent practices or small groups into larger groups that exclusively or principally contracted with the hospital system, or to purchase their practices and make the physicians the employees of the hospital system. Physician-hospital organizations (PHOs) were formed to negotiate managed care contracts, with the hope that these entities would foster physician-system alignment. The new large medical groups generally assumed substantial risk sharing with the health system, and individual physician compensation increasingly became tied at least in part to measures of productivity.

We found that this common approach had only limited success in fostering physician-system alignment. Financial incentives and management-support services provided by the health system were somewhat effective in enhancing physician-system alignment, but structural arrangements and productivity controls were not. As previous studies have also found, we documented that physician participation in structural relationships such as PHOs or IPAs in and of itself did not enhance physicians’ commitment to the health system. When strategic and policy decision making for the medical group was centralized and dominated by the system, physicians were less likely to support the system. Even giving physicians the opportunity to serve on the board of directors of the health system had very little effect. Of particular note was the finding that the common management practice of tying physician compensation to measures of individual productivity had strongly negative effects on physicians’ attitudes toward the health system.

Form of payment and revenue to both the physician group and individual physician, on the other hand, were more likely to improve at least some aspects of physician-system alignment. For example, as the proportion of revenue coming to a medical group from managed care arrangements increased, physicians showed more positive attitudes and loyalty toward the system. Also, as the proportion of individual physician revenue from managed care increased, the greater was the degree of physician alignment. In addition, salaried physicians expressed stronger alignment with the system. Not every financial approach worked, however; the extent to which physicians held equity in medical groups had little or negative effects on physicians’ alignment with the system. Finally, operational support to physician practices, such as extensive management services provided by the health system, appeared to enhance physician-system alignment.

Quality improvement and care management. Although developing a competitive health care marketplace grew out of concerns that medical services were too costly and inefficient, the quality of that care has now become a major national policy issue. Responding to these pressures, health systems have initiated a wide range of efforts to enhance both the quality and the value of medical services through evidence-based care management activities. Health systems generally see physician-system alignment as central to these efforts, recognizing that they will be effective only to the extent that they actually cause physicians to modify their practices and
permit themselves to be held accountable for the quality of their care.

We found that one of the same factors that influences physician-system alignment overall is also important for implementing care management: money. In particular, groups that used multiple compensation incentives and those with greater control over physician salaries had more comprehensive care management practices. Similarly, those that provided financial incentives for participation in care management enhanced their physicians’ comfort with care management.

Beyond compensation strategies, attention to the professional concerns of physicians also was important. For example, when the physicians perceived that their group had a patient-centered focus, there was an even more positive effect on care management than compensation strategies alone were able to achieve. Similarly, physician involvement in the implementation of care management activities enhanced their attitude and behavior regarding care management. On the other hand, when management was more involved in implementing care management activities, the result was a negative effect on physician participation.

II. Health Systems and Effective Alignment Strategies. While the stated policy of many health systems has been to increase physician-system alignment, many of the factors identified above as likely to be effective were not in place, and energy was largely being expended on measures that were not likely to enhance alignment. For example, while financial incentives specifically to participate in care management had a positive effect, most groups did not provide such incentives. Similarly, we found that the number of different types of financial incentives was associated with the comprehensiveness of care management, but plans on average had few such incentives. Management information systems also could provide clinically useful information, but such systems were rare.

Health systems generally also failed to deal effectively with the natural independent-mindedness of professionals such as physicians. Our interviews revealed that the atmosphere within groups was not one that would bring physicians and systems closer together. Because some groups were so recently formed, and others were growing rapidly, there was little sense of a culture that could sustain relationships. Physicians and groups by and large did not display the degree of trust in their systems necessary to have a well-functioning relationship. Leadership problems were widespread, with physicians demonstrating a lack of confidence in administrators, even those who were themselves physicians.

Systems also generally came up short in dealing with fundamental issues of professionalism. A strong patient-centered focus proved to be quite important in promoting care management and accountability, but systems overall were below the midpoint on a scale measuring that focus. Instead of addressing such issues, systems had emphasized getting physicians into PHOs and IPAs, structural measures that, as noted, were not associated with closer physician-system alignment.

Systems were somewhat more successful in using financial levers to create interdependence between themselves and their physicians that encouraged behavior consistent with an alignment of interests. In particular, risk sharing between the physician group and the system through managed care contracts showed evidence of enhancing alignment. But trouble was often brewing just below the surface. Using individual productivity measures to determine physician compensation seemed to alienate physicians from the system rather than to enhance their alignment, yet about one-third of staff physician incentive compensation was based on individual performance. Systems were perceived as having wasted vast sums of money that could have gone to clinical services but were invested in, for example, ill-functioning information systems. These deeply held negative attitudes toward the health systems do not bode well for sustaining physician-system relationships.
Barriers To Alignment

Despite years of steering a course ostensibly intended to lead to successful vertical integration among different health care sectors, a substantial disconnect exists between the major policy shifts that would encourage physician-system alignment and the organizational reality as we perceive it. This emerged even as health systems expressed strong interest in enhancing their relationship with physicians and adopted at least some measures intended to achieve that goal. Although we identified particular activities that promote physician-system alignment, the most effective ones were rarely put in place.

- **Changing public policies.** Why have health systems so often failed to achieve the degree of alignment with their physicians that they set as a goal? First, the public policies encouraging such vertical integration have fluctuated over time. The response to these policies largely depended on the priority they were given in relation to other demands on the health systems and medical groups, as well as the manner in which they were translated into day-to-day practice settings. Health systems can interpret the array of underlying policy pressures in varying ways and proceed down myriad paths in deciding to foster physician integration or not. The inherent difficulty of working out more collaborative relationships between physicians and health systems is made more difficult when the external policy environment creates conflicting incentives and mixed signals regarding the desirability of vertical integration.49

- **Differences of priority.** Second, these systems are generally large organizations with numerous components, physician groups being but one. Physician integration may be given a different priority in different systems, and even in systems that value integration highly, approaches may vary greatly. Also, regardless of their intentions, when institutions initiate change, there may be a disconnect between policy, organizational initiatives, and the net result.50

- **Lack of focus on “physicians’ issues.”** Third, decisions about how to respond to policy pressures are made at the level of the health system governing board and have largely had to deal with broad national or pressing financial concerns rather than the ones of primary importance to physicians. For example, issues of professional prerogatives and control seem to be absent from most policy discussions of integration and thus from institutional responses, yet those issues have a profound impact on physicians’ attitudes and behavior. Overall, policies favoring integration have evoked many health system responses, but systems have not focused on measures directed at issues of importance to their physicians.

- **Conflicting payment incentives.** Fourth, even policies unambiguously favoring some form of integration may have a differential impact on health systems and the physicians they might seek to integrate with. While certain managed care and other cost containment policies made it appear attractive for hospitals to align more closely with physicians, the physicians may have found it in their interest to consolidate among themselves but not with hospitals. In particular, the unexpected failure of global capitation arrangements to dominate provider payments sustained long-standing conflicts between systems and physicians. Instead of hospitals and physicians having a fixed sum to encourage joint efficiencies in providing services, conflicting payment incentives continue in which hospitals’ imperative for revenue and occupied beds can compete with physicians’ desire to treat on an outpatient basis.”
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**Divisive productivity incentives.** Similarly, health systems perceiving substantial financial losses from hastily conceived physician alignment strategies designed for a payment environment that never fully emerged are more likely to focus on divisive physician productivity incentives than on clinically valued aspects of integration. We identified serious problems concerning productivity and compensation incentives at nearly all sites. Systems repeatedly characterized physicians as “loss leaders” in their hospital-dominated systems, while physicians castigated systems for accounting practices that ignored their financial contributions to the system.

**Lack of physician leadership.** Finally, very real barriers to alignment are found on the physician side of the health systems. Our site visits indicated that many physician groups lacked the leadership to participate as effective partners with hospitals and health systems. In spite of the administrative burden they now perceive, physicians are, understandably, preoccupied with practicing medicine. Physicians and management frequently expressed markedly different perspectives on the same issues. Physician leaders who might have staked out stronger arrangements for their medical groups often became health system leaders, leaving a greater vacuum in the practitioner ranks.

**What Does The Future Hold?**

Given the existing disconnect in physician–health system integration, what does the future hold? We found tensions that are likely to result in further instability. For one, physicians’ underlying attitudes were not always as supportive as their behavior, even when the physicians acted in ways that were generally consistent with the goals of the system. In particular, financial interdependence may produce workable arrangements in the short term, but they are not likely to be sustainable if health systems continue to fail to address many issues of importance to physicians.

Current trends on several fronts outside of the health systems also seem to portend increasing tensions in the future. The return of double-digit health care price increases is likely to engender a new round of pressures to constrain costs, perhaps with renewed emphasis on global budgets that would reinvigorate integration into competitive systems. Whether in response to cost containment or other pressures identified above or simply to enhance their market share, health system consolidation may well continue. But hospital-based systems could face a new era of physician–system interaction if the American Medical Association (AMA)–supported movement to unionize employed physicians were to recover from recent legal setbacks and succeed, or if Congress were to give non-employee independent physicians some degree of bargaining rights.

One policy development that might continue to foster physician–system alignment is the current interest in protecting patients by focusing on systems of care, rather than individual providers of care. Development of corporate liability for hospitals over the past thirty-five years led to the imposition of extensive hospital-based processes that were widely perceived by physicians as having little real benefit for quality of care. The newer approach emphasizes outcomes of care and would hold health systems to a new level of accountability. It is unlikely that either health systems or physicians will be able to meet these challenges without closer integration and cooperation in redesigning how health care is delivered and measured. The new accountability demands could push physicians and health systems closer together but could also pull them farther apart. Physicians are unlikely to cooperate with heightened accountability requirements if health systems cannot provide clinically relevant feedback from their data systems and continue to pay inadequate attention to physicians’ patient care concerns.
PHYSICIAN-SYSTEM ALIGNMENT is one key component of vertical integration and appears to be growing in complexity. Our study identified many factors endogenous to health systems that determine the character of their relationships with physicians, as well as many exogenous ones. Systems genuinely interested in enhancing their ties with physicians might well consider addressing the ones under their control while they can, because external developments are likely to further complicate the situation. Policymakers should be cautious about strategies that rely heavily on well-functioning physician–health system units, for the road to physician-system alignment appears to be growing rockier all the time.

The authors thank all of the study systems for their participation in and support of this research. They gratefully acknowledge the helpful comments of the two anonymous reviewers and editor.

NOTES
1. S.M. Shortell et al., “Physician-System Alignment: Introductory Overview,” and subsequent papers, Medical Care 39, no. 7 (Supplement 1, 2001).
11. Ibid.; and Burns et al., “Physician Commitment.”
13. Ibid.
14. Ibid.
17. Ibid.
19. IOM, “Aligning Payment Policies with Quality Improvement,” chap. 8 in Crossing the Quality Chasm.