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HEALTH POLICY BULLETIN

FOCUS: PHYSICIAN ORGANIZATIONS

Increasingly, physicians are aware that managed care plans have eroded their ability to set the terms of medical practice and that forthcoming health care reform will erode them further. In response, doctors are embracing two new entities, physician organizations (POs) and physician hospital organizations (PHOs). Both focus on collaboration rather than competition. The PHO also offers an alternative model for an integrated health care delivery system.

The PO is a business entity that enables physicians to negotiate more effectively with managed care plans and with hospitals. A PO may be a preferred provider organization (PPO), a large multispecialty group practice, an independent-practice-association health maintenance organization (HMO), or several members of a hospital staff who want to be more tightly organized. PO members want to maintain or assert control over medical decision making and the medical aspects of patient care. Most writers suggest that a PO may not be obligated to admit every qualified physician who wants to be included.

The PHO, also a business entity, is a form of integrated health care delivery system. It may be a PPO, an HMO, a multispecialty practice owned by the hospital, or a looser form of organization, such as an affiliation between a PO and the hospital or even coequal partners in a joint venture to provide medical care services to the community. The interdependence of hospitals and physicians and the rapidly changing characteristics of medical practice make the PHO attractive to hospitals and physicians. To be successful, a PHO must (1) be based on a solid analysis of community needs performed in conjunction with business and community leaders and (2) develop a strategy for meeting those needs. Often cited as a successful example of a PHO is the Henry Ford Health System, with its staff of salaried and nonsalaried physicians.

Gilbert Bluhm, M.D., president of the Michigan State Medical Society, and a specialist in rheumatology at Henry Ford Health Systems, said that health care reform has captured doctors' attention. He notes,

> Doctors have become alert to the fact that managed competition and other arrangements will alter relationships. Doctors are going to be looked at more closely and they are unable to control this scrutiny, the relationships between doctors will change, and practice relationships will change. All these changes have gotten their attention like a blow with a two-by-four.

Bluhm also points out that as doctors join managed care groups and physician groups, the resulting changes will mean an increase in the number of relationships doctors have with hospitals and HMOs. One of the beneficial results of POs will be improved quality of care. Bluhm said, "For the individual practitioner, the challenge is to keep abreast of medical science. For the group, the challenge is to make the delivery of health care services personal." The biggest unknown for Bluhm in these developing arrangements is what kind of risk physicians will have in their association with hospitals.

Fred Patterson, M.D., radiologist, Foote Hospital, agrees that change in health care delivery systems is clearly needed. He sees change resulting from the cooperative and collaborative relationships among many groups of people. "For physicians to exercise a leadership role," he observed, "they need to be organized. Organizing, though, is a big and difficult step for doctors but one they need to take to regain the sense of fun in practicing medicine and of having respect in the community."

Part of the impetus for developing POs and PHOs, Patterson believes, arises from the desire of people to predict their health care costs and from the fact that, to paraphrase Tip O'Neill, all health care is local. "There is enough uniqueness in communities to make tailoring organizations and services to each community an imperative," Patterson said.

Some questions remain: Does a PO include every physician on the hospital staff? If it does not, what happens to physicians who are not included? The definition of a PO states explicitly that it is a voluntary organization with strong loyalty to a hospital and common goals and values that can be realized only by working together. "Working together" can have significant antitrust implications, especially if some physicians are excluded and if the result is control of markets and referrals. One can readily envision a situation in which a hospital and a PO form a PHO that effectively locks up the provision of certain services in

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a community. What happens when a new physician wants to be included?

The equal-equal relationship PHO model postulated by some writers does not appear to square well with the reality of organizational life. To date, in most PHO models hospitals are the dominant entity. A model in which both elements remain equal suggests a static system or one in a permanent state of tension and constantly shifting equilibrium; neither is conducive to good, timely decision making. This model also ignores the role of personality in group dynamics—a truism first articulated 80 years ago says that within every group, no matter how democratically structured or how participatory, a few leaders always emerge. Factions allied with one or another of the leaders develop. A further difficulty is the implicit assumption that physician and hospital interests are and will remain congruent and constant, that there would be no divergence of interests. Most observers of the current tug-of-war between medical staffs and hospitals would agree that it will be difficult enough to bring divergent interests into congruence, let alone keep them there.

On the plus side, the new organizations may have considerable potential to cut costs. A PHO that can offer all medical services under one umbrella at a guaranteed price to a third-party payer could expect to have considerable clout in the community. As Dr. Patterson noted, "The driving force for health care reform is that all the systems tried to manage costs to date have been ineffective." For physicians, the PHO structure offers the opportunity to share economic risks with hospitals. For hospitals, who need physicians more than ever to provide patients, the PHO may offer an opportunity to expand the patient care base, thereby ensuring a dependable stream of revenue.

FOCUS: THOUGHTS ABOUT HEALTH CARE REFORM

We asked players and purchasers in health care where they thought health care reform was going at both the state and federal levels.

Edward McRee, president, Michigan Affiliated Health Systems, Inc., observed that "the momentum for change is so high at the local level that changes will occur within the states before they occur at the federal level." McRee sees the federal government as setting some guidelines while leaving the obligation to ensure performance with the states. He said, "I expect to see a lot more state involvement in health care." He also thinks that *systemness*—the ability to take care of a patient along a continuum of care from birth to death instead of providing fractured episodes of care—is important.

Nancy McKeague, director of government relations, Michigan Chamber of Commerce, agrees that the federal reforms will leave flexibility to the states. Her principal concern is that the legislature in Michigan may not yet take health care reform seriously enough to do the necessary work. She notes that, to date, only Representatives Bennane, Hollister, and Jamian have given health care real thought and work. She commented that Michigan is unique in that "there is a contest between small businesses and big business. The auto companies have pointed out the cost shifting between small employers who do not provide insurance and large employers who do."

Randolph Flechsig, president, Hospital Council of East Central Michigan, notes that the longer the Clinton Administration delays making its plan public, the more likely the states will do the work. He sees some form of managed competition with a global budget as the most likely outcome in Michigan, especially since Governor Engler has supported managed competition. He also sees the Michigan Department of Public Health as having a significant role in deciding what the health care system in Michigan will look like.

William Madigan, executive director, Michigan State Medical Society, quoted Ira Magaziner, "The plan is not going to be something everybody is going to like. Everybody is going to have to give a little." For Madigan, the question is, Who gives the most? He noted that every president since 1900 has wanted to change health care, mostly by making small changes and dealing with the larger issues later. "Clinton's approach," he commented, "is to change the big things first—to get around the reluctance of insurers to cover the sick by requiring universal coverage." Choice of physicians and incentives to participate in managed care plans will be significant features, he believes. What the states will do, in his view, is the big unknown.

OF INTEREST

The legislature has returned from its July 4th break. Passage of the medical liability reform bill, the health professionals' licensing and discipline bills, and the certificate of need bill means most of the major health care structural issues have been settled. This still leaves the legislature with universal coverage bills and other measures, such as hospital safety and nursing home inspections. We expect the legislature to continue to be preoccupied principally with school aid and school finance reform.

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