Existing market trends and recently passed healthcare reforms are coming together to create new forces for change in the way healthcare is delivered. This essay describes key market and health reform trends and their consequences. It emphasizes the growing importance of physician–hospital integration for success in the new environment and offers specific actions hospital leaders should consider.

**Market Trends**

**An aging population.** Boomers moving to Medicare and an aging population with complex chronic diseases will result in changes in payer mix and migration to Medicare rates. By 2020 the over-65-year cohort will make up 17 percent of the population (Day 1996) and by 2030 is projected to account for 56 percent of hospital admissions (First Consulting Group 2007). These epidemiological changes will dramatically increase utilization of inpatient services as well as costs of care because of higher acuity, while changes in payer mix will reduce reimbursement for most providers.

**A changing insurance market.** Trends in the insurance market—including a new rate review process, increasing cost pressures on employers, and growth of the individual insurance market through health exchanges—will drive price control in the commercial insurance industry. This will further reduce the potential for reimbursement growth. The net effect will be a strong downward pressure on the bottom line for many hospitals and healthcare systems and an intense effort to remove waste and improve efficiencies.

**Greater provider accountability.** Medicare penalties for healthcare delivery system failures will begin with avoidable readmissions in 2012 and expand to hospital-acquired conditions in 2015 (Commonwealth Fund 2010). These, together with growth of shared savings and bundled payment models, will shift more clinical and financial accountability to providers and will drive a greater focus on patient safety and coordination of inpatient and outpatient care.

**Focus on value.** The increased expectation of higher healthcare value through lower cost per health outcome will drive lower tolerance for provider variation in care, overutilization, and cost differences. This intolerance will be reinforced by higher consumer out-of-pocket costs driven by health plan deductibles that are higher than most outpatient claims and the anticipated growth of individual markets through health reform exchanges.

**Shift to outpatient care.** Ongoing shifts of profitable inpatient services to outpatient care will further strain hospitals and drive more vertical and horizontal integration. This will take the form of highly specialized service lines; regional consolidation to achieve scale needed to drive...
FUTURESCAN SURVEY RESULTS: Physician–Hospital Integration

How likely is it that the following will be seen in your hospital’s area or, if in bold print, your hospital specifically, by 2016?

<table>
<thead>
<tr>
<th></th>
<th>Very Likely (%)</th>
<th>Somewhat Likely (%)</th>
<th>Somewhat Unlikely (%)</th>
<th>Very Unlikely (%)</th>
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<tbody>
<tr>
<td>1. A key divisive force between hospitals and physicians is the hospital’s inability to broaden its mission to prehospital and posthospital care settings over which it has little control. To bridge the gap, your hospital will adopt a more expansive mission by 2016.</td>
<td>27</td>
<td>45</td>
<td>23</td>
<td>5</td>
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<td>2. Hospital boards have the same legal oversight responsibility for the office practice of employed physicians as they do for physicians practicing in the hospital. By 2016, most hospitals will have developed the equivalent of a medical executive committee to assist the board in overseeing office practices.</td>
<td>26</td>
<td>48</td>
<td>22</td>
<td>4</td>
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<td>3. A problem with medical staff bylaws is that they are developed in reaction to adverse court rulings. A more productive tool to govern the medical staff is a well-structured personnel manual that shows how practitioners are integrated into the hospital’s mission. Such a manual will have been adopted by your hospital by 2016.</td>
<td>16</td>
<td>51</td>
<td>27</td>
<td>6</td>
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<td>4. To achieve greater collaboration between hospitals and physicians, current barriers like Federal Trade Commission regulations and Stark and anti-kickback laws will be modified.</td>
<td>51</td>
<td>32</td>
<td>12</td>
<td>5</td>
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<td>5. Bundling of payments or providing global payments will pose a major challenge to your hospital because of the need to negotiate terms of payment with private practice physicians.</td>
<td>52</td>
<td>42</td>
<td>6</td>
<td>1</td>
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<td>6. More than three out of four hospitals will compensate physicians for additional services, such as ensuring emergency department call or contributing to a clinical service line.</td>
<td>12</td>
<td>38</td>
<td>40</td>
<td>10</td>
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<td>7. Physicians will be recruited to your hospital’s medical staff through a screening process that will include psychological tests to help determine “fit” with the organization’s culture.</td>
<td>7</td>
<td>36</td>
<td>41</td>
<td>16</td>
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<td>8. To improve hospital–physician relationships, special self-appreciation meetings will be held by executives and physicians separately. These meetings will emphasize the group’s value to the hospital and not focus on the negative features of the other group. As a result, when negotiations take place between the two groups, their enhanced self-regard will enable each group to compromise with the other group more readily.</td>
<td>7</td>
<td>36</td>
<td>41</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: Percentages in each row may not sum to 100% due to rounding.
What Practitioners Predict

Hospitals will expand their mission statements and develop more oversight mechanisms. To help overcome the divisions between hospitals and physicians, 72 percent of respondents predicted, their hospitals will broaden their missions to include prehospital and posthospital care settings by 2016. Another key governance issue is the legal responsibility of hospital governing boards for the office practices of employed physicians. To help boards in this oversight function, almost three-quarters of respondents say, it is likely most hospitals will develop the equivalent of a medical executive committee governing office practices. However, respondents were split as to whether their own hospitals would develop a personnel manual to govern the medical staff, replacing the current medical staff bylaws.

Physician compensation will increase as a result of legislative and regulatory reforms, bundling of payments, and demands for services to the hospital. Two-thirds of respondents predicted that current barriers to hospital and physician collaboration such as Federal Trade Commission regulations and Stark and anti-kickback laws will be modified by 2016. Over half of respondents thought it “very likely” and an additional 32 percent “somewhat likely” that bundled or global payments will seriously challenge their hospitals because of the need to negotiate terms of payment with private practice physicians. An even higher proportion—fully 94 percent—predict that more than three out of four hospitals will compensate physicians for additional services such as ensuring emergency department call or contributing to a clinical service line.

The prospect for innovations in recruiting and negotiating with physicians is unclear. Respondents were evenly split on the likelihood that their own hospitals’ screening process for physician recruitment will include psychological testing to help determine a physician’s “fit” with the organization’s culture. Similarly, 57 percent thought it unlikely that executives and physicians will hold separate “self-appreciation” meetings to enhance their self-regard. Such self-appreciation meetings prior to negotiations are thought to enable each group to compromise with the other group more readily.

Physicians will require capital to adopt new technologies that will drive higher levels of performance and quality improvement. They also will need expertise to reengineer practices and help to implement market, with intense pressures on costs.

Challenges for Hospitals

Hospitals will need to transition away from the constraints of the traditional voluntary medical staff toward committed physicians who will partner with the hospital and lead hospital priorities around more standardized measures of quality performance, patient safety, efficiency, and patient satisfaction. Such physician commitment does not necessarily mean employment and may be established through other forms of alignment. It may at the same time secure referral streams while avoiding anti-kickback violations.

Challenges for Physicians

Physicians will require capital to adopt new technologies that will drive higher levels of performance and quality improvement. They also will need expertise to reengineer practices and help to implement...
team care. They will seek financial stability as growth in costs outweighs growth in reimbursement.

Consequences
As a result of the challenges described above, more physicians will enter the ranks of employment. Independent physicians will seek links with larger health systems to gain access to capital and reap the infrastructure and management benefits of larger multispecialty medical groups.

More hospitals will consolidate with larger systems to diversify services, gain access to capital and expertise, and integrate providers of inpatient and outpatient care. Hospitals and physicians will jointly pursue clinical integration contracts with aligned incentives that reward collaboration and higher-value healthcare.

Capital will shift toward IT and expertise in managing the total cost of care and away from building bed capacity. Intense efforts will be made to pursue innovations in operational excellence to reduce cost per discharge, coupled with disruptive innovations in new, more efficient care models. Expansion of the number of aligned primary care physicians and specialists will serve to backfill hospital beds as admissions of ambulatory-sensitive conditions and readmissions are reduced.

Implications for Hospital Leaders
In light of the trends described above, hospital leaders should:

Meet with major payers and employers to determine key initiatives to improve the value of healthcare in the community from their perspectives.

Engage the board of directors in discussion about serving populations across the continuum of care, not just inpatient care. Seventy-two percent of practitioners responding to the Futurescan survey predicted that to overcome the division between hospitals and physicians, their hospitals will need to broaden their missions to include pre- and posthospital settings.

Evaluate the hospital’s readiness to be an ACO. Minimally, this should include a critical assessment of:

- The organization’s ability to develop a physician–hospital organization (PHO) or become part of an integrated delivery system.
- The numbers of physicians and patient volume required to manage clinical and financial risk.
- The governance and management capability to be accountable across the continuum of care.
- The capacity to manage total costs across episodes of care and decouple reimbursement from volume and intensity of services.
- The level of incentive alignment between hospital management and physicians to drive the goals of both.
- The ability and desire to be transparent and report performance publicly.

Start to build the structure and function for an ACO by developing the capability to do clinical integration or accept bundled payments, with sharing of rewards with physicians for improved quality and cost-effectiveness (Shields, Sacks, and Patel 2008). Key strategies would include:

- Establishing a legal entity for collaboration, including joint negotiation with physicians for fee-for-service contracts, to ensure coordination of care across care settings. The US Federal Trade Commission and Department of Justice (2004) have established guidelines to avoid antitrust violations, and several organizations have received regulatory approval.
- Establishing physician membership criteria to ensure physicians’ full commitment.
- Developing a common set of standardized performance measures with major payers in the local market to create a clear focus and the ability to assess performance across physicians’ practices.
- Creating a measurement system to track performance and provide ongoing feedback.
- Establishing an incentive system to promote collaboration, create individual and peer pressure to improve performance, and reward better quality and higher efficiency. Such a system could provide the structure to distribute shared savings in a future ACO.
- Developing an infrastructure to help drive clinical performance, using physician-led committees and system capabilities such as disease registries to manage population health.

Establish or expand physician leadership training opportunities. Good clinicians do not necessarily make good administrators. Developing physician leaders will require an explicit program to identify potential leaders, provide formal training in governance, and mentor new leaders with tools that enable objective management of peers toward common agreed-upon goals.

Conclusion
Ongoing market trends and recently passed health reform will drive a higher level of provider accountability for value. ACOs and bundled payments will shift the current focus on volume and unit cost per service toward total cost per health outcome. Success in this environment will require hospitals and physicians...
to work together closely. Although the physician–hospital relationship may take different forms, clinical integration can be an effective chassis on which accountability for value can be built.

References


