

P E R S P E C T I V E

Hospitals And Physicians: Not A Pretty Picture

The existence of so many uninsured Americans is driving the dynamics pushing hospitals and physicians into an adversarial position.

by **Jeff Goldsmith**

ABSTRACT: Hospital-physician relationships in the United States have deteriorated markedly in the past few years. An asymmetry of obligations to caring for the uninsured and inappropriate financial incentives have worsened the conflict between hospitals and physicians in many markets. Sadly, the resources and political bandwidth consumed by managing this conflict have been diverted from the fundamental challenge of providing universal health coverage—the root cause of much of this conflict. [*Health Affairs* 26, no. 1 (2007): w72–w75 (published online 5 December 2006; 10.1377/hlthaff.26.1.w72)]

IN THEIR TIMELY analysis of the state of hospital-physician relations, Robert Berenson and colleagues provide a disturbing portrait of a rapidly unraveling relationship.¹ Generations of hospital executives and physicians have fought over the economic boundary between their respective economic spheres—the health system equivalent of the tide line between the Christian and Muslim worlds left by the collapse of the Ottoman Empire. As economic incentives in the payment system change, new conflicts have flared up along the border.

For two decades, hospitals have steadily lost share in lucrative ambulatory surgery and imaging markets to physician-sponsored enterprises, and there is evidence that the share loss has widened in the past two years.² Hospitals' share of overall health spending has fallen from almost 40 percent in 1980 to around 30 percent today.³

The widening rift between hospitals and physicians exposes the public to medical risks: inconsistent service quality, economically motivated and marginally necessary care, and dis-

parities in access to complex treatment depending on the patient's insurance status. Addressing the policy issues at the root of this split—flawed payment incentives, unfunded service mandates such as the Emergency Medical Treatment and Active Labor Act (EMTALA), hospital tax exemption, and safe harbors for physician-ownership of services and, at the root of many of them, the growing number of uninsured Americans—will grow in urgency as these conflicts deepen.

■ **Physicians' "hostage crisis."** Hospitals have less flexibility to respond to these pressures than their physician communities. EMTALA requires hospitals to provide emergency care to patients around the clock, regardless of their ability to pay, and to maintain access to physician services to support that care. There is no EMTALA obligation for physicians or the ambulatory facilities they own. The voluntary compact between hospitals and physicians whereby physicians, in exchange for hospital privileges, took emergency department (ED) call and provided backup for surgical and cardiac care after hours or on week-

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ends has devolved in many communities into a “hostage crisis,” in which specialty physicians such as neurosurgeons, orthopedic surgeons, and cardiologists are demanding “extra-duty pay” in escalating amounts for care they used to provide hospitals for free.

Many of my hospital executive colleagues believe that physician stipends to cover the hospitals’ twenty-four-hour services have become their most rapidly growing and least controllable expense, exceeding even their pharmacy cost growth. As hospitals grapple with this problem, they confront the beginning of what will become a wave of retirements of baby-boomer specialists and a scarcity of replacement physicians in specialties that have a 24/7 service demand (general surgery, cardiology, and so on).⁴ As specialty physicians become scarcer, their bargaining power with hospitals to demand pay for ED call coverage will increase.⁵

Physician care is increasingly becoming shift work. A new generation of physicians seems unwilling to surrender their private lives to more or less continuous medical practice, particularly as they see the human toll of wrecked marriages, overwhelming stress, and intraprofessional conflict that this practice style has produced among their older colleagues.⁶ It is an understandable and human reaction.

■ **New economic model.** Some physicians are exploiting the asymmetry of legal obligations and tightening physician markets to extract incomes that used to accrue from 100-hour work weeks while working much less. A new and deeply exploitative economic model of medical practice is emerging in some physician communities, particularly in the Sun Belt.

Components of this new economic model include “lecture fees,” free travel, and other perks from drug companies to promote new drugs to physician colleagues; “consulting fees” from device manufacturers to use their

products exclusively; “partnership income” from physician-ownership in lucrative ambulatory facilities such as surgery and imaging centers, as well as in specialty hospitals that provide heart or orthopedic care; and “stipends” from hospitals for critical care coverage that physicians used to provide voluntarily.⁷

Most of these economic arrangements monetize the physician’s ability to steer patients to particular therapies or clinical venues and are completely invisible to patients. In my

opinion, the recent explosive growth of elective procedures under Medicare Part B has been driven in major part by inappropriate economic incentives. Physicians’ facilities-related “partnership income” acts much as a turbocharger bolted onto the already inflationary engine of fee-for-service payment. Berenson and colleagues could test this hypothesis by mapping this Part B cost trend onto their

twelve-community sample and observing whether communities with greater prevalence of physician-owned enterprises have higher Part B cost and volume growth.

Whatever its cause, volume growth in lucrative, high-intensity medical procedures is directly responsible for the recurring formula-driven reductions in physician fees under Part B, and results in a redistribution of wealth inside medical communities from primary care physicians to specialists, contravening the intent of resource-based relative value scale (RBRVS)-based physician payment reforms implemented in the early 1990s.⁸ The continuing cycle of Part B fee reductions and congressional rescissions cries out for a fundamental reexamination of Medicare’s physician payment policies, and an urgent search for a successor to event-driven, fee-based payment.

Berenson and colleagues observe that in some communities, détente has been achieved or hospitals have begun employing physicians to cover their legal obligations, or both. In other communities, however, the smell of

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moral rot and exploitation is almost overpowering. They correctly observe that “low leverage” physicians such as family practitioners and pediatricians, whose incomes have been falling, deeply resent the economically motivated behavior of their more fortunate specialty colleagues.⁹

■ **Desirable policy actions.** Berenson and colleagues identify some policy actions that could reduce economic conflicts between hospitals and physicians, such as eliminating Medicare “reimbursement windfalls” for some types of services, such as cardiac care. The recently neutered diagnosis-related group (DRG) recalibrations would have accomplished some of this, as have the major reductions in Medicare payment for free-standing imaging and office-based nuclear medicine procedures.¹⁰ They would also

undercut the investment rationale for specialty hospitals and ambulatory facilities focused on these services. The emerging conflicts of interest in physician communities could also be addressed by strengthening prohibitions on cash or in-kind payments by pharmaceutical companies and device manufacturers to physicians for any reason, with strict limitations on consultative arrangements.

Berenson and colleagues provide excellent ammunition for those who would widen and brighten the “bright line” between physicians and ownership of the clinical services they direct. There is a compelling argument for ending the “whole hospital” exemption from Stark antikickback laws.¹¹ The “whole hospital” exemption will be responsible not only for a new generation of half-empty heart hospitals, but also the less visible trend of syndication to physician-ownership of marginally needed community hospitals, a costly alternative to simply closing them.¹² Physician support for new facilities should be based on their potential for quality and service improvements and on increased convenience to both patients and physicians, not the sound of coins dropping.

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The real motivation of strengthening self-referral prohibitions is not, as some have recently argued, to protect the hospital’s clinical franchises but, rather, to reinforce the increasingly questionable belief on the part of patients that physicians make clinical decisions based solely on the patient’s best interests.¹³ Absent these policy changes, physicians should be required to disclose to patients both in their offices and on their Web sites both facility ownership and income support from device manufacturers, pharmaceutical firms, and hospitals, so that patients can draw their own conclusions about the motivations behind treatment decisions.

■ **Impact of widening coverage gap.** Tinkering with existing payment models and legal restrictions raises a larger question, however. The growing economic stress on hospitals, and growing tensions with physician communities, are in major part an artifact of the widening health insurance coverage gap. The number of uninsured Americans has grown by more than half since EMTALA was enacted in 1987.¹⁴

EMTALA would be unnecessary, and could be abolished, if we had universal health coverage, as would the host of subsidies (disproportionate-share hospital payments, critical-access subsidies, and so on) hospitals receive to compensate for coverage gaps. Universal coverage would also eliminate much of the rationale for hospital tax exemption.

Robert Clark has famously criticized hospital tax exemption as providing a screen for “for-profit” activities on the parts of their physicians, who make free use of the “community’s” capital.¹⁵ Uwe Reinhardt argued recently for eliminating the hospital tax exemption but letting hospitals credit back against their tax liability the real cost of the community benefits they provide.¹⁶

The same conceptual approach that Reinhardt advocated for hospitals could be applied to physicians in the absence of universal

coverage—for example, providing tax credits in lieu of direct hospital payments for ED and intensive care unit (ICU) consultation and after-hours surgical call coverage, as well as office-based care provided to uninsured patients. Physicians could make voluntary decisions regarding their community service obligations and receive tax benefits in proportion to their effort. The higher their incomes, the more compelling the trade-off between tax credits for “voluntary” activity and taxable stipends from hospitals. Whether or not this would prove cheaper for the federal government than plowing the costs of the stipends into the base of hospital spending requires further analysis.

UNIVERSAL COVERAGE will not alleviate the impending physician shortages created by baby-boomer physician retirements, nor will it alter younger physicians’ desire for more manageable lifestyles. The tragedy is that both energy and dollars expended by policymakers trying to protect one or the other side in this increasingly bitter conflict are being diverted from the essential task of providing universal health coverage for Americans.

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The author thanks William Nelson of Intermountain Health Care and Nathan Kaufman of ACS Healthcare Solutions for their comments on a draft of this paper.

NOTES

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3. C. Smith et al., “National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending,” *Health Affairs* 25, no. 1 (2006): 186–196.
4. E.R. Dorsey, D. Jarjoura, and G.W. Rutecki, “Influence of Controllable Lifestyle on Recent Trends in Specialty Choice by U.S. Medical Students,” *Journal of the American Medical Association* 290, no. 9 (2003): 1173–1178.
5. J. Goldsmith and N. Kaufman, “Between a Rock and a Hard Place: Physician Markets Create New Strategic Problems for Hospitals,” *COR Healthcare Market Strategist* (November 2004).
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7. Regarding drug company “perks,” see C. Elliott, “The Drug Pushers,” *Atlantic Monthly* (April 2006): 82–93; and G. Harris, “Drug Makers Are Still Giving Gifts to Doctors, F.D.A Officials Tell Senators,” *New York Times*, 3 March 2006. Regarding device companies’ actions, see R. Abelson, “Possible Conflicts for Doctors Are Seen on Medical Devices,” *New York Times*, 22 September 2005).
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10. R. Pear, “White House Alters Plan to Make Large Cuts in Hospitals’ Medicare Payments,” *New York Times*, 2 August 2006.
11. See J.K. Iglehart, “The Uncertain Future of Specialty Hospitals,” *New England Journal of Medicine* 352, no. 14 (2005): 1405–1407, for an analysis of the “whole hospital” exemption and its strategic importance for the development of specialty hospitals.
12. V. Galloro, “Running in Syndication,” *Modern Healthcare*, 36, no. 26 (2006): 10.
13. See S.H. Altman, D. Shactman, and E. Eilat, “Could U.S. Hospitals Go the Way of U.S. Airlines?” *Health Affairs* 25, no. 1 (2006): 11–21, for a summary of this argument.
14. See G.R. Wilensky, “Viable Strategies for Dealing with the Uninsured,” *Health Affairs* 6, no. 1 (1987): 33–46, for an estimate of the number of uninsured Americans in 1987.
15. R.C. Clark, “Does the Not-for-Profit Form Fit the Hospital Industry?” *Harvard Law Review* 93, no. 73 (1980): 1416–1489.
16. U.E. Reinhardt, “The Economics of For-Profit and Not-for-Profit Hospitals,” *Health Affairs* 19, no. 6 (2000): 178–186.