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Carol S. Miller

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WHY HOSPITALS AND PHYSICIANS ARE BONDING

by Carol S. Miller

Carol S. Miller is Senior Consultant, Hospital and Practice Management, ELM Services, Inc., Rockville, MD.

Throughout the years, physicians and hospitals have been independent breeds vying for their own autonomy, independence, success and, needless to say, positive bottom lines. Historically, physicians have dominated their practices, built referral bases, and expanded their horizons either by opening secondary offices, adding partners, or affiliating with multiple hospitals. All of this was done to establish additional referral patterns, widen the market base, and increase revenues. Similarly, hospitals expanded their institutional complexes, services, and programs, and began to settle in for a comfortable, profitable future.

However, during the past decade, both hospitals and physicians have been faced with declining levels of reimbursement, decreasing numbers of patients, increasing competition for inpatients and outpatients, scarce resources, and increasing federal and state regulatory demands. Coupled with all of those headaches, hospitals have had to cope with continually declining reserves and net bottom lines, while physicians have experienced an ever-increasing trend of higher expenses compared to revenues.

These elements have placed significant pressure on both physicians and hospitals, forcing them to reduce services and staff, to further integrate and merge programs and/or office practices and, in many instances, they have led to hospital and office closures. All of these occurrences have contributed to an overall decline in both quality of care and program effectiveness.

Options for the 1990s

What are the options for hospitals and physicians in today's environment? They can continue to experience reductions in services, market share, and prestige; they can attempt to maintain the status quo; or they can attempt to resolve the issues at hand.

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In the future, two practice models are likely to be dominant: a physician practice model, such as a Mayo or Cleveland Clinic, and a hospital practice model. The latter model, because of hospitals' size, resources, and technology, is likely to be more widespread. However, such a hospital-dominated practice model will entail a solid, working relationship, a formal agreement, and actual bonding between a physician or physician practice and a hospital.

The concept of hospitals and physicians working in tandem is a viable option, but one that has been slow in coming because of the following perceptions.

Physician Surplus. Hospitals, especially those located in metropolitan areas, still believe that an ample supply of physicians exists in their marketplaces, and that patients will continue to seek inpatient and outpatient services in a hospital setting. As a result, some hospitals are neglecting to develop a plan for future retention of physicians that is based on a cooperative, interactive working relationship. In reality, however, many physicians remain uncommitted to hospitals, as well as their services and programs, because of their limited interactions with hospital administration. Others have sought positions in different areas of the country or have joined managed care programs, such as HMOs. Hospitals must extend their efforts to provide for physician services, to place physicians on administrative committees, to provide "sales representatives" for their offices, and to implement physician referral services, if the concept of "working together as a team" with equal participation, purpose, and power, is to evolve in its true sense.

Competition. Physicians are expanding their office markets while hospitals are developing ambulatory markets with satellite extensions, ambulatory surgical centers, outreach programs, and so forth. This results in direct competition between private practice physicians and community hospitals.

Hospital/Physician Tensions. Natural tensions and conflicts have always existed between hospitals and physicians. With the instability of the health care delivery system, these tensions have continued to escalate, fostering the overall impression that hospitals and physicians cannot operate a business together in a harmonious working environment.

Business Methods. Physicians and hospitals have always had a different culture, style, working environment, and methodology for accomplishing tasks and completing projects. In the past, they have looked upon each other more as adversaries than as colleagues.

Why Bond?

How can these opposites be attracted to each other? What is the common linkage? Why are some oncologists and hospitals actually starting to work together, sharing risks and rewards, sharing financial revenues and expenses, and planning and working together?

The primary reason is that hospitals and oncologists are beginning to realize that they need each other if they are to provide a full spectrum of quality patient services and programs. Oncologists need access to hospitals' resources and technology; hospitals need oncologists' expertise in program development and their patient referrals.

However, both parties have very specific reasons for bonding in today's environment. Hospitals are interested in bonding with oncologists for the following reasons:

1) Due to competition, decreased reimbursement, and the shift from inpatient to outpatient care, hospitals are experiencing continual decreases in their daily census.

2) Medicare, Medicaid, Blue Cross and Blue Shield, commercial insurers, and managed care programs are reducing reimbursement for hospital services, which is impacting the bottom line of most institutions.

3) With the uncertainty of physician commitment, and with the lack of physician loyalty to one institution, hospitals cannot predict or direct the referral patterns of their attending physicians. The following saying applies to this scenario:

> "Patients select physicians from referral sources or recommendations from friends; physicians select hospitals because of convenience, quality of programs, the service and skills of the nursing staff, and the availability of beds, especially on a dedicated unit; but patients rarely select the hospital."

4) Many hospitals in today's market are developing similar services, especially oncology programs. On the one hand, hospitals can develop their programs and market and advertise the services to the community and the general staff, but hospitals cannot refer patients to their own programs. The system still in existence today is one in which primary care physicians refer patients to specialty physicians who, in turn, refer patients to hospital programs.

5) It is the perception of hospitals that physicians practicing independently from the hospital campus contribute to poor quality and management of patient care. Hospitals believe that a centrally-operated program with integrated nursing and physician care, and with common goals and purposes, will positively affect the overall quality of patient care.

> ***Hospitals and oncologists are beginning to realize that they need each other if they are to provide a full spectrum of quality patient services and programs***

6) The oncology product line has been hovering around number four or five in the hospital ranks for the past few years. With the increased incidence of cancer and an aging population, it is projected that the oncology product line will move to number two or three within the next couple of years. Therefore, most hospitals are placing greater emphasis on developing an oncology product line, and they want to ensure that all the necessary components for success are present, including physicians.

7) Patients, physicians, and staff perceive that the hospital is a complete community cancer center when it provides all of the elements essential to the diagnosis, treatment, and follow up of cancer patients in one location, including a dedicated inpatient oncology unit, a radiation therapy service, outpatient cancer services, dedicated oncology physicians located adjacent to the center, and the continuum of outreach services.

On the other hand, physicians are interested in bonding with hospitals for the following reasons:

1) Physicians are paying an ever-increasing premium to operate their private offices. They must provide competitive salaries and benefits for office staff, including nurses, office managers, billing clerks, receptionists, accountants, lab technicians, and others. They are also experiencing higher drug costs and general office expenses, including supplies, furniture, stationary, postage, legal fees, marketing, advertising, and photocopying and computer services. All of these expenses are being generated at the same time that revenues from insurance carriers and direct patient payments are declining.
2) The discounting of physician fees by managed care programs, reductions from Medicare and Medicaid's set fee structures, and the realignment of current CPT codes have negatively impacted physician reimbursement in an office setting.
3) Over the years, physicians have enjoyed affiliations with multiple hospitals and practiced in multiple office locations. However, as time constraints increase and commuting becomes more cumbersome, physicians are leaning toward consolidation, convenience, accessibility, and availability in providing oncology services.
4) Private physician practices have limited resources for purchasing expensive new technology and products; whereas, hospitals, because of their size and investment power, can more easily invest in and afford new technology.
5) The influx of physicians and resultant competition, the increase of out-of-pocket expenses for patients, and the restrictions of managed care programs on who can provide services, have led to a decline in patient visits to private offices.
6) Physicians are beginning to realize that changing factors in the medical practice environment are affecting their financial future, and they are starting to take steps to protect and secure their future roles, relationships, and positions.
7) Hospitals not only provide direct patient care, but an entire array of other services, such as marketing, printing, public relations, laboratory services, educational meetings, banking, etc., which provides a hidden benefit to physicians who are assessing a potential relationship.
8) Regardless of the physician's specialty or type of practice, there is usually one hospital that is perceived as providing the physician with a feeling of welcome, comfort, and security. These hospitals foster relationships with staff, nurses, and referring physicians, and they encourage physicians to become involved in the internal management of the hospital and, as a result, they are beginning to ensure the future allegiance of their physicians.

Next Month...

Physician Practice Models

The next installment of this two-part article on physician-hospital bonding will examine four specific physician practice models: private practice, private practice with a hospital lease, hospital employees, and contracted or "bonded" physicians.

The author, Carol S. Miller, will describe the pros and cons of each type of practice model for both hospitals and physicians. In addition, the article, which will appear in the Spring 1991 edition of *Oncology Issues*, will discuss components of each model, such as hospital-physician contract rate negotiations.

Mutual Gains

Once previous adversarial feelings have been overcome, hospitals and physicians will be able to move forward, develop an acceptable working relationship, establish a clear, concise contractual agreement, create an environment of equal autonomy and decisionmaking, and provide a successful and prosperous business arrangement that is accepted by all parties within and outside of the hospital community. An offshoot of this relationship will be the following mutual gains:
1) Integrated, comprehensive management (physicians, nurses, administration, and staff) and quality of patient care for oncology services.
2) Collaborative planning and management of the oncology program, including quality assurance, utilization review, new technology, expansion of services, resolution of problems, continuing education, and so forth.
3) The convenience of a fully-integrated cancer service for patients and their families.
4) Decreased financial headaches for physicians, including the burdens of billing, overhead expenses, and other direct expenses, and increased revenues for both parties. This relief translates into physicians who can begin to enjoy clinical practice, research activities, and educational symposiums.
5) Centralization of a unified product line for the hospital with enhancement of outpatient ancillary revenues.
6) Improved hospital image and future growth of the oncology program. In today's uncertain health care market, the bonding of physicians with hospitals and hospitals with physicians, and the development of sound working relationships needs to be carefully considered by both parties. ■

Resources for Cancer Survivors

The National Coalition for Cancer Survivorship has published an almanac of practical resources for cancer survivors, entitled "Charting the Journey." The almanac addresses cancer survivors' special medical, psychological, and legal needs. Charting the Journey, which was written by members of the Coalition, covers such topics as dealing with the trauma of diagnosis, evaluating and selecting proper medical treatment, coping with side effects of the disease, evaluating alternative treatments, managing the costs of treatment and recovery, dealing with employment discrimination, obtaining appropriate health and life insurance, locating peer-support groups and community resources, and many other pertinent areas of concern.The paperback book is available at a cost of $14.95 per copy. It is available at bookstores, or it can be ordered by calling 800/221-7945, ext. 577.