Physician-Driven Integration

A Response to the Corporatization of Medicine
Physician-Driven Integration: A Response To the Corporatization of Medicine

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Abstract

Spurred by escalating costs, American health care has become increasingly integrated. Most of this consolidation has been driven by non-physicians: insurance companies, existing HMOs, hospitals, and physician management firms. The trend toward integration offers physicians an opportunity to reclaim their profession and to reinstitute professional values in health care. This involves taking charge of purchaser-prompted efforts to practice more efficiently and improve quality, efforts which require collaborative practice styles. Physicians take full ownership of this responsibility when they accept financial risk through capitated payment. Accepting financial risk obviates the need for external review by managed care organizations (MCO)s. MCOs do expect, however, that risk-bearing physician groups demonstrate cost effectiveness and quality through data. A tightly integrated group of physicians is also well-positioned to contract directly with employers, government, and purchasing groups, eliminating the need for an intermediary MCO.

The American College of Physicians encourages physician-led integration as the surest way to retain physician values at the core of the health care system. All forms of integration must respond to the need for efficiency and quality, the physician's central role and responsibility in these processes, and the primacy of patient interest. This necessitates the involvement of physicians at the highest levels of leadership, particularly in the areas of quality and utilization management, and collaborative involvement of all physicians in these processes. Professional societies have a responsibility to support physicians by providing information, guidance, and referrals; by arranging support networks; and sponsoring or financing educational programs. Moreover, medical schools will need to increase instruction on health care economics, business issues, cost-efficient practice patterns, epidemiology, population-based medicine, and evidence-based practice. Perhaps most importantly, schools, like the profession, will need to impart a milieu more supportive of collaborative practice.

Finally, the College calls for study of the effects of various types of physician integration on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures.
INTRODUCTION

In an era of wondrous health care technology, the most powerful medical instrument remains the physician's pen. Without the physician's order, no one delivers or receives medical care. No other entity in the health care system is vested with this prerogative -- not hospitals, not insurers, not HMOs, not employers, not politicians, not patients.

Despite this simple reality, many physicians are understandably beleaguered by the monumental changes in health care as it evolves from cottage industry to a consolidated and incorporated one. Although physicians are poised at the center of the action, relatively few have managed to seize control of their own professional destinies, and certainly the profession as a whole has not. This is not surprising, for the changes confronting the medical profession are as profound as any profession has ever faced. With control of a $1 trillion dollar industry hanging in the balance, the power of the stakeholders is tidal in force.

The sociology of our century is one that honored and esteemed science and professional authority, and then uprooted this authority as if mistaking the arrival of the third millennium for the first or second. As science advanced throughout most of the 20th century, so did the authority of medicine. Lay people did not or could not understand it, nor did most really want to. Their trust was part of the cure. (1, Blumenthal) The precipitous events responsible for the undoing of medical authority -- economic, cultural, and some self-inflicted -- are less important than the changes themselves: Payers, administrators, public officials, even other health professionals, have intruded into the once sacred turf of the physician-patient relationship.

In the interest of both professional and public health, the American College of Physicians calls on physicians to stand up and reclaim their profession. The nation needs a patient-focused and professionally dedicated medical profession. In the face of commercial intermediaries in health care delivery, patients must be able to trust that their best interests are protected by their doctors. (2, Crawshaw) As Friedman deftly explains, "that basic, trusting, intimate interaction is at the heart and soul of everything we seek to do in health care. And we are playing too fast and loose with it. There is too much playing doctor by computers and entrepreneurs. There is too much second-guessing of clinicians by nonclinicians....There is too much economic intrusion on the exercise of clinical judgment." (3, Friedman)

Since mid-1995, the AMA Private Sector Advocacy and Support Team has encouraged
physicians to report their experiences in this area. Common responses included impeded ability to make referrals, plan denial of proposed services or hospital admissions, gag rules restricting the content of physicians' medical counseling. (4, AMA) The UR procedures are intrusive and time-consuming, and physicians spend more and more time on administrative, rather than clinical duties. On average, physicians now spend 20 percent of their time on paperwork. (5, Cave) Almost any physician, and many patients, can report disruptions in office visits made by non-clinician insurance company reviewers who, reading from script over the telephone, require explanations of some treatment or hospital stay before authorizing its payment. In addition to external case-by-case review, health plans routinely rate physicians on time spent with patients, hospital admissions, procedures performed, referrals made; yet the corresponding measures of quality are not nearly as refined. The hammer over the heads of physicians is the threat of deselection or reduced compensation. Patients are beginning to amplify physician demands to restore the primacy of the doctor-patient relationship. Toward this end, a number of states have enacted laws prohibiting MCO restrictions on physician advice to patients and other medical decisions. Additionally, the President has launched a national commission to address patient concerns with managed care quality.

The paper lays out an approach for physician integration and the formation of physician organizations (POs), not as profit-making ventures but as stewards and rebuilders of the profession. The notion of physician integration can be limited or broad. Integration can refer to a physician-owned health plan that bears full-risk, contracts directly with purchasers of health care, and owns assets such as hospitals or laboratories. Alternatively, integration can be the merging of practices into a smaller, non-risk bearing network that performs its own utilization and quality management and contracts with hospitals and laboratories for services. In general, integration increases a group’s value to managed care firms and the group’s leverage in contract negotiations. To fully explicate the concept of physician integration, the paper describes and analyzes the emerging organizational landscape of health care delivery in general; the effects of structural changes on the health of patients and the profession; and the role physicians have played, can play, and should play in the transformation.

The analysis leads the College to the following policy positions:

The ACP encourages physician-led integration as the surest way to retain professional values at the core of the health care system. A physician organization should be bound first and foremost to professional values, while commercial organizations are bound to stockholders. Additionally, both evidence and logic suggests that integrated practice and professional collaboration may improve quality of care.

In all forms of integration, physicians should have a commitment to and a central role in accountability processes. This necessitates the involvement of physicians at the highest levels of organizational leadership, particularly in the areas of quality and utilization management, and the collaborative involvement of all physicians in these processes. Legislation and licensing of health care delivery organizations should require physician leadership of utilization and quality management in all organizations. (6, ACP "Quality Standards")

Highly integrated practices with established quality and utilization systems are better positioned
to deliver quality, cost-effective care than are loosely-knit networks or individual practices, which do not have the necessary tools.

In choosing any type of practice organization, physicians have the responsibility to evaluate and place a high priority on physician development and leadership of collaborative quality improvement and clinical activities and on overall physician leadership in the organization. The College supports the right of physicians to choose any type of practice arrangement.

Patients have the right to full disclosure of all methods of reimbursement, quality management, and utilization review in any health care delivery organization. Legislation and licensing should require such disclosure.

No delivery organization, accountability process, or reimbursement structure can fully resolve the conflicts posed between economic self-interest and professional commitment to the patient’s best interest. Neither purchaser demand nor regulatory oversight can stimulate the type of quality that comes from professional commitment to altruism, research, and self-improvement.

Professional societies have a responsibility to support physicians attempting to form integrated organizations by providing information, guidance, and referrals; by arranging support networks; and by sponsoring or financing educational programs.

Medical schools should include instruction on health care economics, business issues, cost-efficient practice patterns, epidemiology, population-based medicine, and evidence-based practice. Alternatively, medical schools, like the profession itself, are called on to impart a milieu that supports collaborative practice.

The College, other professional organizations, universities, and government should support vigorous research of the effects of various types of integration and reimbursement structures on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures.

The paper is meant as an opening statement on the issue of physician-driven health care delivery, which the College sees as one mechanism for sustaining physician values as the health care industry consolidates. In addition to setting forth policy, the paper is intended to give information and direction to the many physicians struggling against the gales of economic consolidation.

**THE INTEGRATED LANDSCAPE**

After decades of intense cost escalation, purchasers demanded, and health care entrepreneurs responded with, managed care products designed to cut costs through restricting choice, utilization, and reimbursement. Restricted physician panels and regional market shakeouts led physicians and hospitals to merge with themselves and each other to increase leverage in negotiating contracts with managed care organizations (MCOs). Discounted fee-for-service, capitation, withholds and bonus pools, and salary have become predominant
modes of reimbursement.

Enrollment in all forms of managed care plans (HMOs, PPOs, and point-of-service plans) covers the vast majority of the population with employer-sponsored coverage, 79 percent in 1995 compared to 29 percent in 1988. Enrollment in HMOs, the most tightly restricted type of managed care plan, grew from 18 percent in 1988 to 29 percent in 1995. (7, KPMG in HIAA) As of Jan. 1, 1995, nearly a fifth (19.4 percent) of the entire U.S. population (publicly insured, privately insured, uninsured), was enrolled in HMOs, up from 17.3 percent of the population a year earlier. (8, Interstudy) The consensus of industry and health policy analysts is that managed care enrollment will continue to grow; less certain are the rate and geographic concentration of growth or the types of delivery structure and reimbursement methods that will prevail. (9 Ginsburg; 10, Baldassano) Recent growth of managed care has been greatest in states without a history of employer support for managed care -- Arizona, North Carolina, Connecticut (13, GHAA). Managed Care penetration is greatest in Western states -- California, Oregon, Colorado, Arizona -- and in Minnesota, Wisconsin, Massachusetts, Rhode Island, Connecticut, Maryland. (7, KPMG) While HMO and point-of-service enrollment has grown reliably from 1992 through 1995, PPO enrollment declined.

In response, increasing numbers of physicians, especially those in groups, are signing managed care contracts, either discounted fee-for-service or full or partial capitation. Almost all medical groups (91 percent) had contracts with HMOs or PPOs by 1995, up from 62 percent a year earlier. (14, Hoechst, Marion, Roussel). The average number of contracts is 4.6 and 9.0, respectively. (15, AMA "Medical Groups") A third of groups participate in a Physician Hospital Organization (PHO), and 75 percent of these allow the PHO to negotiate managed care contracts. (15, AMA "Medical Groups") On average, physicians with managed care contracts derived 35 percent of their revenue from these contracts in 1993. (16, Iglehart) Just over one-quarter of physicians had contracts with IPAs (non-exclusive networks formed to contract with HMOs), accounting for 4 percent of income, on average. (17, PPRC "Physician-Driven Integration").

The recent trend toward managed care coincides with a renewal of growth in both the number of group practices and the number of physicians in group practice. Presumably, physicians are merging with one another to more effectively contract with HMOs. The trend toward group practice began decades ago. In 1965, 10.6 percent of non-federal physicians practiced in groups; by 1995, 34.4 percent did, a 643 percent increase. The number of groups grew by 361 percent during the same period. In 1988, the increase in the number of groups slowed, and picked up again significantly in 1991, just as the drive toward national health reform and managed care intensified. Between 1991 and 1995, the number of medical groups grew from 16,576 to 19,787, a 16.4 percent increase. The trend toward group practice is indirectly supported by a decline in solo and two-partner practices. The number of self-employed physicians in this practice category declined from more than 50 percent in 1987 to 37 percent in 1993. (15, AMA "Medical Groups"; 17, PPRC "Physician-Driven Integration")

While growing in number, group practices also have been growing in size and consolidating, particularly those groups with 5-99 physicians. One gauge of consolidation is the percent distribution of groups by size category over time. In 1984, small groups of 3 or 4 physicians comprised 54.8 percent of all groups, declining to 45.9 percent in 1995. Larger groups
of 5 99 grew from 44.1 percent of groups in 1984 to 53 percent of all groups in 1995. The number of extremely large groups, 100 or more, remained relatively constant at just over 1 percent. (15, AMA “Medical Groups”)

Another measure of group consolidation is found in the distribution of groups by specialty composition over time. In 1965, multi-specialty groups, which have always been the largest, were three times larger, on average, than other groups. By 1995, multi-specialty groups were four times larger, on average, than single specialty groups and four and a half times larger than family/general practice groups. A third measure of consolidation is the distribution of group physicians by group specialty composition over time. Interestingly, in the volatile period from 1988 to 1995, the portion of group physicians in multi-specialty groups rose from 48.7 percent to 53.7 percent, while the portion in single specialty and family/general practice declined, from 46.2 percent to 41.9 percent and from 5.1 percent to 4.4 percent respectively. (15, AMA “Medical Groups”) According to a 1992 Hospitals Magazine Survey of 506 hospital CEOs, multi-specialty group practices were showing the strongest growth of all types of practice. Thirty-four percent reported multi-specialties growing rapidly, compared to 18 percent reporting single-specialty groups growing rapidly. Fifty percent reported solo practices declining. (18, Hospitals) One reason for the strong showing of multi-specialty groups may be a greater demand, in a managed care environment, for the broad range of services these groups can offer.

The landscape of group practice by specialty and size now looks like this: Overall, most groups are small, but most group physicians practice in large groups. Groups with 3 or 4 physicians represent 46 percent of all groups but only 14.7 percent of all group physicians. Groups with 100 or more physicians represent just one percent of all groups but 30.7 percent of all group physicians. Most group physicians (56 percent) practice in groups of 16 or more. (15, AMA “Medical Groups”)

Similarly, most groups are single specialty, but most group physicians practice in multi-specialty groups, because of their larger size. Single specialty groups represent 69.7 percent of all groups and 41.9 percent of all group physicians, whereas multi-specialty groups represent 22.3 percent of all groups and 53.7 percent of all group physicians. Family/general practice groups represent 8.0 percent of all groups and 4.4 percent of all group physicians. Multi-specialty groups have a mean of 25.4 physicians; single specialty groups 6.2 physicians, and family/general practice 5.6 physicians. (15, AMA “Medical Groups”)

The vast majority of groups contract with both HMOs and PPOs. A third of groups, 33.7 percent, participate in a PHO. (15, AMA “Medical Groups”)

A 1994 national survey of physicians by the Physician Payment Review Commission (PPRC), found that nearly a fifth (19.1 percent) of physicians experienced a structural change in their practice in the previous two years -- either some contractual affiliation with another entity or a merger that created a new entity. Medical specialists experienced the most change -- 22.2 percent, with primary care physicians second at 20.5 percent. The most frequently cited reason for joining with other physicians was leverage in negotiations with insurers (89 percent). Of the 81.9 percent of physicians who reported no structural change, nearly half (48.3 percent) said they are likely to make such a change in the future. So, three-fifths of all physicians have responded or
Examine the above data, it is clear that external economic influences on physicians have forced them together. This very dynamic offers physicians an opportunity to reclaim their profession, to reinstitute professional values in health care, by taking charge of the purchaser-prompted efforts to practice more efficiently and improve quality, efforts which are enhanced by collaborative practice styles. While non-risk-bearing integration arrangements are valuable, physicians take complete charge and ownership when they seek and obtain financial risk through partially or fully capitated payment. Bearing financial risk obviates the need for external review by MCOs. MCOs do expect, however, that risk-bearing physician groups demonstrate cost effectiveness and quality through data. Very tightly integrated groups of physicians are positioned to contract directly with employers, government, and purchasing groups, obviating the need for an intermediary MCO. Some large, multi-specialty group practices and looser networks formed by medical societies have embarked on this approach.

Dr. David J. Ottensmeyer, wrote 10 years ago as president of Lovelace Medical Foundation and the American Group Practice Association: "Physicians are being told that they must and will change more in the next five years than they have in the past 100. The profession is being forced into a basic reexamination of its ethical, scientific, sociologic, business, professional, and organization concepts. It is probable that the profession will emerge from the 1990s a much altered institution." (20, Ottensmeyer). So far, Dr. Ottensmeyer has been right.
THE NATURE OF RESTRUCTURING

Health care system restructuring is occurring simultaneously in three dimensions -- delivery of care, reimbursement for care, and retail packaging of health plans. Each dimension can be distinguished by its major player: in delivery, the physician; in reimbursement, the payer; in retail packaging, the patient. Each of these players confronts a different set of choices when interacting with the health care system.

Patients and Plan Choices

Systemic changes are probably simplest for patients because the complexities of contracting and reimbursement are largely hidden from patient view. Primary choices in health plans are twofold: traditional indemnity insurance or a form of managed care. While there are no agreed upon definitions of managed care or its varying forms, this paper uses these characteristics: integration of financing and delivery of medical care through contracts with selected providers; cost control through attempts to modify physician and patient behavior; and restriction of enrollee access to non-participating providers. (16, Iglehart)

Managed care can be further divided into three types: health maintenance organizations, preferred provider organizations, and point-of-service plans. The main differential characteristic of an HMO is that services must be obtained from a provider in the HMO, which will pay no part of care received from outside providers. A PPO encourages use of a select panel of providers by reimbursing patients more for care received by participating providers. Point-of-service plans, less well defined, allow patients to use panel providers or non-panel providers at will, and the corresponding payment rules apply to each service rendered. The added choice in point-of-service is reflected in a higher premium. Because the market is constantly evolving, other variations may and probably do exist. Also available to some patients are company medical services, such as those provided historically by railroads and lumber and mining companies. Today, large firms such as John Deere and Company and Southern Pacific Railroad provide extensive medical services directly to employees. Xerox, IBM, Minneapolis Honeywell, and 3M Corp. also employ physicians at some locations. (4, AMA "Insurance Companies")

Physicians and Health Care Delivery

The delivery options for physicians and other providers are more complex. The trend is toward integration, which can be physician-driven, hospital-driven, or externally driven by insurers or physician management companies. This paper is most concerned with physician-driven strategies.

Physician-Driven Integration

The broad categories of choices that confront physicians are these:

Institutional employment: corporate, hospital, university, government, and HMO

Practice size and composition: solo, single-specialty group, and multi-specialty group
Group structure: Independent Practice Association (IPA), Group Practice Without Walls (GPWW), Physician Organization (PO), and Fully Integrated Regional Group (FIRG)

Contractual affiliations with payers: Physician Hospital Organizations (PHOs), PPOs, HMOs, Management Service Organizations (MSOs), employers, purchasing groups, and government

Physician-run health plans which bear full risk and contract directly with employers, purchasing groups, and government

Definitions of these structures are sometimes vague, and there is no universally agreed upon taxonomy. Moreover, physician integration is highly dynamic, and organizational structures merge and form new types with some frequency. Therefore, the labels in current use are only approximate descriptions of stops along a continuum. Definitional issues include contract exclusivity; panel exclusivity; practice ownership; extent of risk-bearing; practice and network legal status, which determines ability to accumulate capital and purchase facilities; and degree of quality management, utilization management, and reliance on practice guidelines and protocols.

The following definitions have been developed based on a review of the literature:

IPA: a loose confederation of physicians formed to contract with MCOs (HMOs and PPOs), employers, and other purchasers. Member groups and physicians continue to own their own practices and see patients from a variety of health plans. In the 1980s, physicians formed IPAs on their own as a first response to managed care; more recently, insurers have organized them. An IPA usually accepts any physician willing to take the reimbursement negotiated with MCOs. A physician or group's membership in an IPA is probably invisible to patients, who belong to the health plan that contracts with the IPA. Physicians in IPAs run their own offices; computer and information systems are separate. Because of their inclusiveness, IPAs generally have too many specialists. IPAs generally do not impose their own utilization or quality guidelines, although members must meet the guidelines of the MCO. (21, Unland “Guide to Forming Physician Directed Health Plans”)

Group Practice Without Walls (GPWW): a confederation of physicians formed not only to contract with managed care organizations but also to share administration and reduce overhead. Member physicians continue to own their own practices. Functions of the GPWW include negotiating contracts, billing, and purchasing supplies. Individual physicians and groups share the cost of these services. (5, Cave) Typically, the GPWW is formed by a centralized clinic -- such as a large primary care practice or multi-specialty group practice -- which adds individual physicians or small groups in satellite offices. (17, PPRC) GPWWs also can be formed by individual physicians or small groups wishing to ease into larger group organizations more capable of obtaining and negotiating managed care contracts. Integration consultants report that MCOs increasingly seek large, tightly integrated groups for contracts because of the market share these groups control. (22, Anderson; 23, Gevinson) GPWWs are relatively inexpensive to set up -- $30,000 to $100,000, depending on the level of information technology desired. Analysts expect many of these entities to evolve into more tightly integrated groups over time. While
individual physicians own their own practices, the GPWW is a legal corporation with a stock structure and board of directors.

Examples of GPWWs include Sutter Medical Group, Sacramento, CA; Oxford Health Plans, Norwalk, CT; New Mexico Medical Group, Albuquerque, NM; and Montana Associated Physicians, Billings MT. (22, Anderson; 23, Gevinson)

**Physician Organization (PO):** This term could be used interchangeably with GPWW, but is probably best described as a more integrated form of a GPWW. (21, Unland “A Guide”) In addition to all the characteristics of a GPWW, a PO shares and requires adherence to utilization management and quality assurance programs and carefully selects physicians based on geography and specialty, with a preponderance of generalists. Physicians continue to own their practices. It is commitment to group standards and discipline that makes contracting with this type of physician network desirable for HMOs and other payers. POs may contract on their own with payers, or they may form contractual entities (master contracts) with hospitals, home health agencies, and other providers which, in turn, contract with payers. Like IPAs, the PO entity may be invisible to patients.

**Fully Integrated Regional Group (FIRG):** A FIRG is the most advanced form of physician integration. A FIRG shares all above characteristics of a PO, except that a FIRG is a merged corporation of individual physician practices which give up their separate corporate identities. Physicians take ownership of the merged corporation through stock and abide by the same terms of practice -- from quality and utilization management to billing and reimbursement arrangements with payers. The advantages of a FIRG are increased ability to aggregate capital and own facilities without violating self-referral and other laws, a unified practice and business strategy uniting all physicians, allegiance to one practice entity which does not compete for contracts with member physician practices, and the leanest possible overhead structure. With this level of integration, a FIRG is positioned to contract directly with employers and purchasing groups, which may require state licensing as an HMO and increased capital requirements.

Both POs and FIRGS must raise capital for operating expenses, sophisticated information technology, network-wide staff, and attorney and management consultant fees. Funds typically come from contributions of accounts receivable, cash contributions of physician members, up-front payments from capitation contracts, and bank loans. Physicians in groups which foresee integration in the future may want to hold some earnings in reserve, which can be leveraged against bank loans, to help with capital formation.

Many of the large multi-specialty physician groups, such as those in California -- Bristol Park Medical, Friendly Hills HealthCare Network, HealthCare Partners Medical Group, Mullikin Medical Centers, Palo Alto Medical Foundation, and San Jose Medical Group -- meet the definition of a FIRG. (24, Robinson)

Some physician groups are moving toward direct contracting with employers, acting as their own HMOs. These include some FIRGs and some looser IPA-type networks begun by medical societies or groups of physicians. These looser types of medical society HMOs are operating or in planning in about half the states. Typically, the medical society or large group of
physicians will work with consultants to organize a business plan, raise capital by offering stock to any interested physician, and attempt to market the plan to purchasers. The prospect of long-term success for many of these endeavors is questionable because they lack tight integration involving discretionary recruitment, a balance of primary care physicians and specialists, effective utilization and quality management, and experience in designing health plan products to employer specifications.

The pervasiveness of direct contracting is unclear because no employer or benefits group tracks it. Purchasers who contract directly with providers include Caterpillar, John Deere, Hershey Foods, and Parker Hannifin Corp. In Minnesota, the huge Buyers Health Care Action Group, which represents 24 of the nation's largest self-insured employers, including General Mills, Honeywell, and 3M, planned to shift its business to direct contracts with individual physician groups. Minnesota state employees will also purchase care through BHCAG. The adoption of direct contracting by BHCAG is extremely significant because it calls into question the value added by huge managed care organizations such as those in Minnesota, where four plans have dominated the market. The basis of competition among the four plans is vague because most physicians belong to several, diluting strategies to encourage cost effectiveness and high quality by any single MCO. Purchasers have found that physicians tend not to differentiate by payer and therefore not to respond to any specific MCO incentives. Market share changes not in relation to price and quality but for unrelated reasons, such as changes in an employer's cost-sharing terms or plan deselection of physician. Under direct contracting, all employees represented by BHCAG will receive a defined contribution toward health coverage and have access to any physician group with a BHCAG contract. Physician groups will have to demonstrate price and quality to retain patients. By enabling physicians and patients to remain together, this arrangement enhances continuity of care and eliminates third-party intermediaries from the physician-patient relationship. (25, Cunningham; 26, Christianson; 27, Papplebaum)

"Other-Driven" Integration

While we focus on physician-driven integration, physicians within and outside of these organizations must interact closely with integrated structures driven by other players in the health care system. It is crucial that physicians understand these "other-driven" structures, which are actually further along the continuum of integration, not a surprising observation given the institutional head start they enjoy. Hospitals, for example, have made a far more concerted effort than physicians to control managed care contracting; about 20 percent of hospitals have formed PHOs, and most others are in the process of doing so. (17, PPRC "Provider-Driven Integration"). In 1994, 7 percent of physicians said their practice had joined a PHO in the previous two years (19, PPRC "Results of the 1994 Survey of Physicians"); 27 percent of physician groups surveyed by the American Group Practice Association were involved in some joint-venture arrangement with a hospital. (14, Hoechst Marion Roussel) Hospitals own some or all of the practices of 11 percent of physicians. (19, PPRC "Results of the 1994 Survey")

Like physician-driven integration, hospital driven integration takes a number of forms: (28, Burns)

A physician-hospital organization is the least integrated of physician-hospital
arrangements, a contractual arrangement formed for the purpose of presenting a unified front in managed care contracting. The PHO may provide administrative services and monitor physician management of resources. The PHO may involve a hospital's entire medical staff or contract more selectively with physicians.

A management service organization is a PHO organized as a free-standing corporation. (MSO is also the term used to describe arrangements integrated by investor-owned practice management firms, described below.) The MSO provides management and administrative services to physicians and often employs non-physician staff, in exchange for either a flat fee or percentage of revenues. Larger hospital MSOs (as well as larger non-hospital, for-profit MSOs) may purchase physician practices and employ physicians directly or contract for their professional services. (17, PPRC “Provider Driven Integration”) In 1994, 9 percent of physicians had contracts with an MSO, one-third of them owned completely by a hospital. (19, PPRC “Results of the 1994 Survey”)

A foundation model is a hospital subsidiary similar to an MSO, except that the foundation owns the tangible and intangible assets of practices. Non-physician personnel are employed by the foundation; physicians provide their services to the foundation under a professional services contract. Tax-exempt foundations have access to cheaper capital; however, contracting physicians may not hold more than 20 percent of the board seats.

An integrated health organization (IHO) is a single legal entity with hospital, medical services, and educational and research subsidiaries. It acts as its own HMO, contracting directly with purchasers and bearing full risk. The IHO is commonly thought of as the nirvana of integration forms, overshadowing the important advantages of its physician-driven counterpart -- the FIRG -- mainly, that the FIRG does not subsidize costly hospitals but can provide the continuum of care through ownership of or contractual relations with hospitals. Nonetheless, an IHO yields the benefits of integrated, comprehensive, community-based care that avoids duplication.

Most physician-hospital arrangements are at the earliest stages of integration, simple PHOs. Many of these arrangements are laden with and overly influenced by specialists, who generate more income for hospitals than primary care physicians. PHOs have attracted many physicians who feel threatened by HMO market penetration and compelled to join for fear of being left out of managed care contracts. When faced with the challenge of integrating, physicians are relieved by the services a hospital can provide -- capital; administrative structure; marketing expertise; information technology for data collection; quality and utilization management; and billing. Economically and professionally, however, the arrangement is an odd one with misaligned incentives. Hospitals depend for income on patient admissions, procedures, and surgeries; yet the success of the joint venture depends on avoiding costly procedures and admissions. This involves continuous monitoring of utilization, review of outcomes, and changing physician behavior. Physicians do the hard work but share income with hospitals, sometimes subsidizing their inefficiencies. For these reasons, expectations for the future of PHOs are mixed.

Hospital-driven integration arrangements such as PHOs are more likely to succeed if they
give physicians, especially primary care physicians, equal or greater control over the joint
venture from the initial stages of formation. (29, Advisory Board “The Grand Alliance;” 28,
Burns; 30, Johns; 31, Kleiman; 32 Unland “Hospitals v. Physicians”) Given the hierarchical
nature of hospital administration vis a vis medical staffs, these types of PHOs are probably in the
minority. PHO characteristics important to physicians include: appointment of a physician CEO;
at least 50 percent physician board representation; contracting controlled by physicians with
technical support from the hospital; physician-run utilization management and quality assurance;
and heavy emphasis on primary care.

In addition to hospital-driven integration, another phenomenon is integration driven by
practice management firms such as Caremark, Phycor, Coastal Physician Group, MedPartners, or
Pacific Physician Services. One analyst estimates about 5-10 percent of practicing physicians are
organized by an investor-owned for-profit practice management company, which number in the
dozen and continue to proliferate. Many have gone public and earn rates of return well into the
double digits. (33, Barnett)

These firms, some run by physicians, organize group practices into networks for the
purpose of attracting managed care contracts. Increasingly, MCOs seek contracts with physician
groups which can provide a broad range of primary care and specialty services, accept risk
(capitated payment), and manage and demonstrate quality through provider profiling and use of
clinical protocols. Practice management firms either buy group practices outright or offer
business management services in arrangements similar to the hospital-driven MSO. Physicians
sometimes receive equity in the company in lieu of cash for their practices.

The proliferation of management firms arises from Wall Street’s realization that
physicians generate 70-80 percent of all health care costs and hold the keys to cost containment
so desired by purchasers. For physicians, most who lack the infrastructure desired by MCOs,
management companies offer a solution with several advantages: First, physicians can retain
their existing practices, although they must subscribe to unified utilization and quality
management processes. Second, the economic incentives of the management company and the
physician are aligned. That is, both seek to optimize the physician’s economic performance.
Unlike in hospital-driven integration, physicians are not in the position of feeding hospital
referrals. Whereas physicians are vendors to HMOs and PHOs, physicians are the customers of
management companies. This relationship may lend physicians more control than other
non-physician-driven entities. Third, physicians under management firms are less distracted by
administrative duties. Fourth, through joint purchasing, billing, and other administrative
efficiencies, management firms are positioned to reduce overhead. The major disadvantage,
which for many physicians outweighs all advantages, is the emphasis on economic performance
and the for-profit status of the management firms.

Another form of integration is insurer-driven. Aetna Life and Casualty, Cigna, Prudential
Insurance Company, Blue Cross/Blue Shield plans, and other regional companies have
established HMOs, including staff models which employ physicians. Aetna has also established
an MSO which contracts with or employs physicians. About 1,100 physicians serve in groups
managed by Aetna (mostly in southern California). Cigna employs 1,000 physicians in staff-
model HMOs in eight states. Reimbursement for these employees is salaried. (4, AMA
Reimbursement Changes

In discussing reimbursement, it is helpful to understand that a given physician group may be paid through a combination of methods, depending on the provisions of the group’s varying contracts with payers. It is also useful to distinguish between individual physician payment within a group, which is determined by the group, and individual or group payment by an HMO, insurer, or other payer, which is determined by the contract.

Although related to structural changes in the health care system, changes in the reimbursement of physician practices is a somewhat separate dynamic, for the incentives of reimbursement methods may not align with a particular delivery structure to produce the intended outcomes of cost containment, high-quality care, or both. For example, capitated reimbursement without structural integration incorporating quality and utilization management processes encourages fewer services of lesser intensity. Without structural safeguards, this may result in low-quality care and, ultimately, bad outcomes. Likewise, discounted fee-for-service reimbursement to a loose network subject to external utilization review may do a better job of safeguarding quality, since the physician has no incentive to reduce care other than hassle; however, this combination of structure and reimbursement has not achieved significant cost containment. A 1992 Foster Higgins survey found utilization review saved indemnity plans a meager 6 percent, raising the question of whether UR even pays for itself. (34, Advisory Board “Capitation Strategies”)

It was this failure of external review in the discounted fee-for-service system that prompted payers to look “back to the future” to capitation -- originally known as pre-paid health insurance. Capitation is a prospective reimbursement mechanism for health coverage calculated per patient per month. It is also a mechanism for transferring risk. In traditional indemnity health insurance, employers capitate insurers, who promise to provide patients a fixed set of services for a fixed period of time for a fixed premium. The insurer pays providers for each covered service the patient uses. The economic incentive for the provider is to perform more services. Insurers attempted to counter this incentive with external controls on physician practice behavior. In the more contemporary version of capitation, insurers or managed care organizations pass the risk along to physicians through capitating reimbursement the same way employers capitate insurers. An advantage of accepting risk is freedom from onerous and disparate externally imposed utilization and practice protocols required by managed care organizations. However, to maintain viability in the marketplace and professional standards of quality, physicians must establish their own systems for quality assurance and utilization management. This is where reimbursement methods intersect with delivery system structure: Highly integrated practices with established quality and utilization systems are better positioned to deliver quality, cost-effective care than are loosely-knit networks or individual practices, which do not have the necessary tools.

Capitation has proven more successful at cost reduction than external UR, according to the 1992 Foster Higgins survey, in which insurers report 25 percent savings from capitation. (34, Advisory Board “Capitation Strategies”) Capitation methods of reimbursement are being incorporated into the myriad of evolving delivery structures. This explains the growth in both
capitated reimbursement and membership in HMOs. (Most HMOs capitate some or all medical services.) In 1980, 5 percent of primary care reimbursement was capitated; in 1990 the portion had nearly doubled. The PPRC 1994 National Survey of Physicians found that 50 percent of physicians are affiliated with at least one financial risk plan (either capitated or discounted fee-for-service including a withhold); 69 percent reported having multiple affiliations (a mean of 6) with a risk plan. Of the 50 percent of physicians with a risk plan affiliation, the main plan of more than a third (37 percent) pays capitated reimbursement. Using these figures, the main plans of nearly a fifth (19 percent) of physicians pay by capitation. Capitated reimbursement is more prevalent in the main plans of primary care physicians (53 percent), followed by medical specialists (34.3 percent), and in larger groups than smaller groups. Sixty percent of groups with 25 or more physicians are reimbursed by capitation in their main plans. (PPRC, “Results of 1994 Survey”)

Capitation has gained an audience because much of the managed care industry is finding that the most effective way to produce optimal cost and quality is for physicians themselves to lead and operate the tracking and measuring efforts. Institutions can offer capital and administrative services such as claims processing; but insurers, HMOs and hospitals are too removed to affect the cost and quality of care. Hospitals, for example, lack governance structures with which to control clinical cost decisions. Insurers and MCOs are even farther removed from control over clinical cost decisions. Insurers’ first response to cost consciousness -- external case-by-case review and restricted choice of panels -- has not fundamentally changed health care delivery. The basis of competition, even for MCOs, remains aggressive underwriting and growing enrollment of healthy people -- the same strategies used by indemnity firms. Public support for state and federal insurance reform is likely, eventually, to constrain competition on the basis of risk selection, while managed care saturation will mitigate the profits available from volume. (35, Goldsmith)

At the same time they are promoting capitation, payers are also stingy about letting go of the capitated dollar. One explanation for this paradox is that payers need to know that the providers with whom they do business have the utilization management systems in place to monitor and control costs. Specialty societies promote capitation to their members like pharmaceuticals promote drug samples, whether or not physicians are integrated enough to handle it. Another explanation for reluctance to grant capitated contracts is payer desire to arbitrage the savings from cost efficiencies achieved by physicians. Having discovered their ability to demand low-cost and high-quality health care, some large self-insured employers are reportedly turning back to fee-for-service reimbursement so they themselves can track profit and retain as much as possible. While this development reestablishes incentives to provide more services, employers count on their purchasing leverage to discourage cost increases. (36, Hickey) It will be important to monitor how these dynamics play out, whether employers’ desire for continuity outweighs the implied threat to change vendors.

It should not go unnoticed that, in shifting risk, MCOs make themselves vulnerable to obsolescence. Under capitation, MCOs give up their ability to achieve savings through efficiencies yet continue to face high fixed costs. Thus, MCOs limit their financial liabilities at the risk of limiting their profits, calling into question the long-term role of MCOs in the health care marketplace. This paradox explains why large insurers, like hospitals, are forming their own
MCOs through acquisition of physician practices and employment of physicians; why small insurers are promoting medical savings accounts (to preserve fee-for-service medicine); and why physician groups are seeking to establish their own MCOs or equity in those in which they practice.
THE FUTURE OF INTEGRATION

For many years, the prevailing thought among health care analysts was that vertical integration (financial and structural consolidation of all health care services, organized by traditional HMOs, hospitals, or physicians) would achieve the optimal level of quality and efficiency. However, the marketplace may not see it that way.

In addition to low cost and high quality, employers and employees are beginning to demand choice as well, and vertically integrated systems limit choice. Physician-driven vertically integrated systems such as those in California -- Kaiser and Friendly Hills, for example -- are losing money. "Virtual integration," rather than vertical integration, responds to market demand for low cost, high quality, and broad choice. (36, Hickey)

In virtual or contractual integration, providers contract with many others for all levels of care, seeking the optimal combination of low cost, high quality, and broad choice. Multiple forms of virtual integration are possible. For example, an internal medicine group can contract with other primary care and specialty physicians, seeking global or nuclear capitation for all services and subcontracting for specialty and hospital care. The primary care group may seek an HMO or insurance license and attempt to contract directly with employers; the group may sign a "master contract" with an HMO; the group may contract with an insurer for third party administration and other insurance-related services; or the group may contract with an MSO for management and contract negotiation services.

Direct contracting has risks for physician groups which do not appreciate the costs and complexities of the insurance role. These include claims processing; data collection; health plan design; and marketing of health plans. Designing plans to employer specifications and marketing plans are particularly difficult, requiring expertise in benefits, open-ended products such as point-of-service options, cost sharing arrangements, and actuarial work. The key to successful contractual integration is to engineer a relationship between players which produces value for all parties and which recognizes the need of insurers to make money and of providers to achieve the best outcome for their patients. Physicians have a great deal of leverage in these relationships because they, and no one else, write orders. (36, Hickey)
QUALITY AND ETHICAL CONSIDERATIONS OF INTEGRATION

The increasingly organizational nature of health care delivery and accompanying cost control efforts are undeniable developments. The question the College asks is not how physicians can stop the inevitable; rather, we ask how physicians, as a profession, can imbue the new environment with professional values that promote quality.

The emergence of physician-driven delivery organizations and capitated reimbursement raises concerns that arbitraging will predominate over clinical concerns; that physician managers will begin to identify more with bureaucracy than patient needs; that the physician-patient relationship will suffer as care becomes less personalized. Consider first economic incentives, which are unavoidable in any health care delivery structure. In the fee-for-service system, insurers are encouraged to curtail care, which could be necessary if not lifesaving; physicians have an incentive to provide more care, which could be unnecessary if not risky. Estimates of overutilization in indemnity plans are about 20 percent. Capitation encourages both MCOs and physicians to restrict care. Ultimately, under any system, a physician must rely on professional values to provide high-quality care and lay economic incentives aside. Salaried reimbursement may be most neutral; yet even salary has been ascribed the potential to skew physicians' best professional judgment by virtue of adherence to organizational objectives. (3, Friedman; 37, AMA “Corporate Practice of Medicine”)

In fact, there is no evidence that capitated care adversely affects quality, and there is some suggesting pre-paid care might provide better care. A comprehensive literature analysis by Miller and Luft of studies between 1980 and 1994 found that HMO and indemnity plans provided enrollees with comparable quality of care, based on process or outcomes measures. Fourteen of 17 observations from 16 studies showed better or equivalent quality-of-care results for HMO enrollees compared to fee-for-service enrollees for a wide range of conditions and interventions. Two medical outcomes studies of patients with mental illness showed solidly unfavorable results for HMOs. (38, Miller) In a previous analysis of data before 1980, Luft also found that HMOs deliver care as good as or better than fee-for-service care. Cunningham and Williamson found that 53 of 80 measures of quality revealed superior care in HMOs; 19 measures showed similar quality or inconclusive results; and nine measures showed inferior quality. Other studies support the finding of equivalent or improved care in HMOs or larger organizations. In 1994, Advisory Board researchers wrote that they found no evidence of inferior quality in capitated systems. Nor did this author find any in an extensive literature search. Most of the literature focuses on HMOs, with earlier studies focusing more specifically on pre-paid care.

There is also evidence that larger, more integrated delivery organizations have an inherent capability to improve quality of care because of improved competency from higher volumes of service, the interdependence of staff, and effective leadership. (39, Eisenberg; 40, Burns “Trends and Models”) Eisenberg, writing in 1988, summarized the literature: Shortell and Flood found that more highly organized medical staffs in hospitals deliver higher quality of care. Clinical outcomes are improved by increased physician coordination, staff differentiation, and physician input into health care delivery processes. Rhee and Eisenberg concluded, separately,
that the quality of outpatient care is strongly affected by colleagues' performance. Stross and Eisenberg concluded in separate studies that clinical leadership enhances quality and influences physician behavior.

Evidence of benefits from physician quality management activities is found in a survey of the American Group Practice Association membership: 57 percent of AGPA groups cited a reduction in practice pattern variations -- an indicator of quality -- as a result of practice guidelines. Thirty-eight percent of groups found areas for quality improvement and 32 percent found improvements in pharmaceutical therapy. (14, Hocchst, Marion Roussel) While patient satisfaction is not a true measure of quality, it is noteworthy that a recent survey by the California-based Center for the Study of Services found physician-directed groups generated the highest rates of consumer satisfaction. (41, CSS)

**Physician Integration as a Mechanism to Promote Quality Care**

The traditional multi-specialty group practice that emerged in the early part of this century is a prototype of the physician integration necessary to meet the demands of the health care marketplace and to protect medical professionalism. (20, Ottenmeyer) These include the more well-known clinics such as the Mayo, Fargo, and Palo Alto clinics, and others such as the Strub, Ochsner, Carle, Wausa, Monroe, and East Madison clinics. They flourished in small cities in the upper Midwest and West, mostly, which lacked the infrastructure provided by hospitals and medical schools in the East as well as the organized professional opposition. These clinics, usually run by a prominent internist or surgeon, grew out of a recognition of the added value of group health care delivery. The Mayo Clinic, for example, developed the capability for pathological analysis while surgery was still in progress. In 1910, William Mayo called medicine a "cooperative science" and individualism in medicine unsustainable. Physicians who worked with or observed the Mayos came to similar conclusions and started their own clinics -- the Menninger Clinic in Topeka and the Guthrie Clinic in Sayre, PA, for example. Starr quotes Menninger saying to his three sons: "I have been to the Mayos and I have seen a great thing. You boys are going to be doctors and we are going to have a clinic like that right here in Topeka."

The value of coordinated medical groups also left an impression on doctors in the military medical corps during W.W.I, and the number of clinics swelled after the war. Another harbinger of the future value of integrated health care delivery was the observation in 1915 by reformer Michael Davis, who saw group practice as a way of coordinating care as more patients began to self-refer to specialists. Davis wrote: "Modern industry is the result of specialization, based upon progress in pure and applied science, plus organization. In Modern medicine, we have developed specialization ... but in private practice we have not developed organization. (42, Starr)

Only a small portion of the income of these multi-specialty clinics was pre-paid. The prepayment movement became popular in the 1930s and added the notion of equity to the value of organized care, which was already considered efficient and of high-quality. Pre-payment offered comprehensive care to a large population at a time when health care was becoming more effective and, therefore, more expensive and less attainable. Intrinsically, it emphasized coordination and prevention.
The first solidified attempt to provide pre-paid comprehensive care was undertaken in rural Oklahoma by Dr. Michael Shadid, motivated by a mid-life reassessment of his career. And what a mid-life crisis it must have been, for his cooperative survived numerous attempts by the state medical society to revoke his license and discredit the clinic to recruits. Farmers interceded with the state legislature to save Shadid’s license. However, the medical society responded by dissolving, reforming 18 months later without him, and withdrawing Shadid’s malpractice insurance. Other rural health care cooperatives emerged soon after Shadid’s, encouraged by the Farm Security Administration; however, the rural cooperative movement proved ultimately unable to withstand the pressures from organized medicine.

Other, more lasting examples of early pre-paid health care include the Group Health Cooperative of Puget Sound, Kaiser, the Group Health Association of Washington, D.C., and the Health Insurance Program of New York. These survived largely because they had the resources to build their own hospitals and could therefore operate outside the influence of organized medicine. Their survival, in fact, encouraged state professional societies to establish their own risk-bearing plans in order to compete, just as many medical societies are doing today in response to a similar growth in prepaid managed care plans. For decades, prepaid health plans remained a minor part of health care delivery, overshadowed by the surge of indemnity insurance after World War II. Rising health costs and government support contributed to another wave of popularity in the 1970s. Now, after two decades of even more extreme escalation in health costs, prepaid health care has found widespread popularity.

Despite their rejection by organized medicine, multi-specialty physician groups are based on a tradition of physician ownership and control of the health care system. (20, Ottensmeyer) One wonders whether medicine would be facing the contemporary challenges of outside intrusion into clinical care if the profession had given its support to the earliest group practices. (3, Friedman) Integrated multi-specialty physician groups, contracting with payers as FIRGS or POs, are ideally positioned to function in today’s complex marketplace. They are uniquely structured to foster collaboration in research as well as clinical practice, and collaboration can produce a whole that is greater than the sum of its parts. This collaborative structure has implications for quality enhancement that benefits patients as well as the profession and practice of medicine.

As an example, biomedical research affects nearly every medical specialty. The Ochsner Clinic is one of several which has established a biomedical research laboratory that complements the specific clinical research programs of the various internal medicine specialties as well as the clinic. The approach is cost-efficient and provides a source of expertise and consultation supportive of clinicians and researchers in multiple specialties. (43, Re) At a more clinical level, close integration of multiple specialties in a group facilitates consultation across specialties, sharing of knowledge, and more efficient division of labor between specialists and generalists.

While focusing on physician-driven integration, the College recognizes the potential for effective integration driven by other institutions, particularly hospitals. All forms of integration must respond to the need for efficiency and quality, the physician’s central role and responsibility in these processes, and the supremacy of patient interest. This necessitates the involvement of
physicians at the highest levels of leadership, particularly in the areas of quality and utilization management, and collaborative involvement of all physicians in these processes. (44, ACP "Oversight of Medical Care"). Separate studies by Palmer and Deuschle have found that the success of quality improvement programs or peer review processes depends on physician involvement.

In choosing any type of practice organization, physicians should place a high priority on physician development and leadership of collaborative quality improvement and clinical activities and on overall physician leadership in the organization. The College supports the choice of any physician to choose any practice arrangement. At the same time, we encourage physician-led integration, and other forms which recognize and support the physician's central role, as the surest way to retain physician values at the core of the health care system.

The theory behind physician-driven health care delivery is that firms managed and directed by a profession are more likely to bear the values of that profession. The migration of other professional industries toward collaborative partnerships is telling. Smooth and seamless functioning of a medical practice, which enhances medical and economic performance, requires organizational structures and management principles specific to a professionally dominated organization and a medical organization. (45, Fogle; 46, Shortell) The current environment in many managed care settings has largely ignored these basic tenants undergirding professional organizations in health care. Physician leadership of their own practice organizations can be an important tool for reclaiming medical professionalism.

Physicians, like all professionals and all human beings, maintain self-interests along with professional values. In the final analysis, no external influence can fully resolve these conflicts. Peer influence within a practice organization may lend support, but individual physicians set their own values and act on them. Just like an insurer-formed MCO, a physician organization under capitation can choose to favor economic self-interest by cutting corners. An insurer MCO, however, is bound to stockholders, not professional values. Fortunately, the market is beginning to merge the interests of commercial and professional interests by demanding quality as well as price; however, no profession can afford to rely wholly on the market's drive for quality. Because of "asymmetries of information" between doctor and patient -- an asymmetry patients depend upon -- neither purchaser demand nor regulatory oversight can stimulate the type of quality that comes from professional commitment to altruism, research, and self-improvement. (1, Blumenthal)

While physicians traditionally have believed that their professional autonomy safeguards patient quality, they have done little historically to hold themselves accountable to one another. (39, Eisenberg) A new understanding of professional autonomy as a collaborative endeavor will foster peer accountability and respond to society's expectation that medicine, like all professions, regulate itself. Autonomy "is not a divine right of medical or other professionals. Rather ... it is a legal, institutional, and moral privilege that is granted by society and that must be earned by health care providers through observing certain standards of behavior ....," Blumenthal wrote. More importantly, an integrated approach to health care delivery will help physicians achieve their own expectations for quality.
With the speed of health system restructuring, physicians cannot wait for the results of research to determine what course of action best serves their profession and its goal of quality, cost-effective medicine. Research, however, is needed. The College calls for study of the effects of various types of physician integration on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures. (46, Shortell) Studies are also needed on the effects of various reimbursement arrangements on outcomes, physician visits per patient, and use of procedures and tests. (38, Miller) In addition, because for-profit health care delivery systems are a new development, the College seeks a thoughtful exploration of the inherent advantages and disadvantages of for-profit delivery systems vis a vis not-for-profit systems, as well as empirical research on the effects of profit status on access to care, cost of care, medical outcomes, and medical and technological advancement.
CONCLUSION

The challenges facing physicians today are daunting. Doubts abound, within and outside the profession, about the ability of physicians to work collaboratively, manage effectively, and meet the challenges posed by time, money, change, risk, and entrepreneurship. (47, Lee; 48, Mellinger-Blouch; 49, Wagner; 31, Kleiman; 50, Baker; 51, Kent) Physicians need a great deal more advice and information than is available in this paper, much of it legal in nature, for example, knowledge of anti-trust law, self-referral guidelines, state corporate practice of medicine laws, and state insurance regulation. Still, plenty of physicians have integrated and continue to integrate successfully. Merging practices is an important first step, with its own set of challenges. (52, Cerne; 53, Slomski) Forming a more integrated physician network is, of course, more involved than combining practices. (Unland, “A Guide to Forming Physician Networks;” 54, Hilgers; 55, Williams; 56, Riley; 57, Medical Economics; 58, George; 59, Freudenheim; 60, Advisory Board “To the Greater Good”)

Professional societies have a responsibility to support physicians by providing information, guidance, and referrals, and by arranging support networks or sponsoring or financing educational programs. A variety of publications and programs have been developed by the American College of Physicians and other professional organizations, many of them extremely informative. Medical schools will need to increase instruction on health care economics, business issues, cost-efficient practice patterns, epidemiology, population-based medicine, and -- perhaps most importantly -- impart a milieu more supportive of collaborative practice.

The next frontier in health economics is likely to hinge on this ability to think and act in groups, and to consider patients as both individuals and part of a population. With the spread of managed care based on capitation and integration of health care delivery, large plans may bear increasingly similar price and choice selections. The trend has already begun in advanced markets, such as California and Minneapolis, and is a stage in the economic development of most industries. What will be the next stage of competition in health care?

Goldsmith predicts that large regional plans will gain competitive advantage by demonstrating improved health status among their covered populations compared to other covered populations. Measures may include disease-free years, restored functional capacity, and functional lifespan extended. These are constructive, patient-focused goals for the future of managed care, based on professional values. Physicians who choose to position themselves at the helm of managed care organizations have the opportunity to bring quality care and patient welfare to the top of the managed care agenda.
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