



APRIL 2001  
VOLUME 4  
ISSUE 3

# HEALTH CARE FINANCING & ORGANIZATION FINDINGS BRIEF

## Health Plan Payments Can Motivate Tighter Integration Between Physicians and Hospitals *Effects on Cost Remain Elusive*

“The perception of rapid and frenetic change in health care may be an illusion because much change that occurs is at the surface of the institution’s structure and not deep within internal processes and functions.”  
— Gloria Bazzoli,  
Northwestern  
University.

Much has been written lately about the rapid change in organizational and financial arrangements among health plans, hospitals, and physician groups. Beyond “moving the deck chairs,” however, are these organizations really integrating in ways that are likely to reap benefits for the organizations and, ultimately, patients? A study led by Gloria Bazzoli, Ph.D., at the Institute for Health Services Research and Policy at Northwestern University, along with co-principal investigators Lawton Burns, Ph.D., also at Northwestern, and Robert Miller, Ph.D., at the University of California – San Francisco, examined the relationships between physician-hospital arrangements and managed care organizations to determine their effects on organizational integration and on costs for hospital-based care. They found that global capitation did motivate tighter integration between physicians and hospitals during the study period, but they did not find a link between integration and cost of care.

Noting that the number of physician-hospital arrangements nearly doubled between 1993 and 1995, the team’s central hypothesis was that managed care penetration and global capitation would lead to greater process integration between physicians and hospitals (e.g., streamlined administrative and practice management services, etc.) and that hospitals within such networks would then experience decreased costs of care. “We wanted to assess whether the transfer of fiscal responsibility to health providers for the services they deliver holds promise for more effective management of health care delivery and more cost-effective care, both of which are important objectives of private and public policy,” says Bazzoli.

### What is Global Capitation?

Since the early 1990s, managed care has come to dominate the U.S. health care system. Con-

current with this growth, health providers have taken on increased financial risk from health plans for medical service use, sometimes through global capitation. This payment system combines institutional (e.g., hospital or other facility) and clinical (e.g., physician or other practitioner) reimbursement into a pre-determined monthly payment for each health plan member. Global capitation provides motivation for health providers to contain costs in two ways: 1) it transfers financial risk of health service use for a given set of enrollees to providers; and 2) it allows providers to reap the benefits of successful cost-saving measures. While the issue of health care quality is also an important factor in assessing the effects of global capitation and integration, it was not examined in this study.

### Background

To study the relationship between the capitated contracting used by health maintenance organizations (HMOs), physician-hospital integration, and the cost of care in hospitals, the researchers analyzed a special survey conducted by the American Hospital Association (AHA) in 1995. The AHA surveyed hospitals that reported having various formal physician-hospital organizations in 1993, so only hospitals that had been implementing these organizational strategies for at least two years were studied. The survey questions related to 44 different activities associated with physician-hospital integration, as well as the global capitation contracts held by management service organizations, physician-hospital organizations, and other types of provider networks. Detailed empirical analysis focused on more than 300 urban hospitals that had complete data on physician-hospital integrative activities, capitated covered lives, and other variables relevant to the relationships being addressed.

The researchers assessed the potential effects of global capitation on: 1) the integration of functional, financial, and clinical processes between physicians and hospitals; and 2) its effects in conjunction with process integration on hospital costs. They found that hospitals were using a variety of strategies to integrate with physicians, and that physician-hospital systems were more integrated where they received global capitation payments for a large number of health plan members. Integration took several forms, including: 1) physician involvement in hospital governance; 2) physician salary arrangements with hospitals; 3) administrative and practice management services; 4) financial risk-sharing arrangements between physicians and hospitals; 5) joint ventures to create new service lines; and 6) computer linkages.

### **The Future of Physician-hospital Arrangements**

To further explore these relationships, Bazzoli and Miller conducted case studies of capitated physician organizations and health systems in three markets (Portland, Ore.; St. Louis, Mo.; and San Diego, Calif.) in 1995. They found that organizations were beginning to develop the capabilities to manage capitation, but in some instances, friction between physician organizations and hospital-led health systems had developed as both organizations pursued these arrangements with HMOs. "The findings suggested that health systems needed to seriously re-think their local strategies of pursuing capitated contracts and aligning with capitated physician organizations, especially to focus on facilitative rather than competitive roles," Bazzoli says.

When physician-hospital organizational arrangements first hit the radar screen, there were concerns among health care advocates and others regarding potential anti-competitive effects and possible institutional insolvency for organizations unprepared to manage financial risk. As noted above, study findings suggest that global capitation has not reduced hospital costs as anticipated. This may explain the increasing reluctance of hospital-led health systems to pursue capitated payment arrangements. Existing evidence suggests that some physician-hospital arrangements dissolved during the late 1990s, most likely because they did not achieve sufficient value for affiliated physicians and hospitals. For those that have been successful, Bazzoli suggests that leadership, commitment, and continued market pressures are likely important factors. As interest in capitated arrangements declines, an important question is

whether the types of process integration that have been implemented between physicians and hospitals will continue.

Studying physician-hospital arrangements requires digging beneath the surface to make meaningful distinctions between those arrangements that "made difficult decisions and affected change," and those that "mimicked others in their market without acting upon their stated objectives." During the course of this study, the research team had to re-survey many physician-hospital organizations to get a more comprehensive understanding of their functions and activities. Bazzoli warns, therefore, that policymakers should not rush to judgment until new organizational forms are more fully understood.

"It is important that we understand market and organizational factors essential for successful and sustained organizational change," says Bazzoli, especially given the substantial investment of resources institutions make in the change process. "It is also important for policymakers to better understand what new organizational forms are actually doing, rather than allow themselves to be caught up in the rhetoric of organizational objectives promulgated by institutions implementing change."

### **Next Steps for Policymakers and Researchers**

Bazzoli identified the following questions as areas for future study: How does physician-hospital integration affect the quality of care in hospitals? Does physician-hospital integration have an impact on physician costs more so than on hospital costs? What characteristics make some strategic alliances successful in bargaining with large managed care companies?

In addition to large-scale surveys, says Bazzoli, researchers should employ case study methodology to investigate the actual workings of new organizational arrangements in depth. She notes that in the rapidly changing environment of contemporary American health care, the lag between research and timely reform can be problematic. She also notes, however, that the perception of rapid and frenetic change in health care may be an illusion because much change that occurs is at the surface of the institution's structure and not deep within internal processes and functions.

"For policymakers to enact well-informed and efficacious policy," says Bazzoli, "it may be worthwhile for them to wait and learn what the health services research community is finding about the nature and depth of change occurring in health organizations." ■



## **HCFO FINDINGS BRIEF**

**APRIL 2001**

ACADEMY  
FOR HEALTH SERVICES  
RESEARCH AND  
HEALTH POLICY  
1801 K Street, NW  
Suite 701-L  
Washington, DC 20006  
Tel: 202-292-6700  
Fax: 202-292-6800  
Web: [www.hcfo.net](http://www.hcfo.net)  
E-mail: [HCFO@ahsrhp.org](mailto:HCFO@ahsrhp.org)

*Program Director*  
Anne K. Gauthier

*Deputy Director*  
Deborah L. Rogal

*Senior Research Manager*  
Jason S. Lee, Ph.D.

*Editor*  
Carole C. Lee

*Assistant Editor*  
LeAnne B. DeFrancesco

*Writer*  
Junette L. McWilliams