

Employing the Medical Staff: The Cure for What Ails Us

What makes the United States so different than other countries in health care? The usual answer is our unique approach to access, particularly the absence of a social contract ensuring basic medical services for everyone. In every other developed country, health care is a right; nobody is denied services for lack of insurance. Consequently, universal access has become the key focus of U.S. health reformers. They assume we will achieve the lower costs and better health of comparable countries—12 percent of gross domestic product instead of 17 percent and a life expectancy one to three years longer—when all Americans have health insurance.

The conventional wisdom of health reform fails to address a much more important difference between the care delivery systems in the United States and other countries, which is the economic relationship between hospitals and their medical staffs. We are the only developed country where physicians who work *in* hospitals do not work *for* hospitals. With very few exceptions, hospital-based physicians in other countries do not have private practices. They are employees of the hospital where they work or the health system that operates it. (Physicians who practice in the community do not have hospital privileges; they refer their patients to a hospital service when inpatient care is needed.)

This difference in hospital-physician relationships probably explains far more of the difference in national health expenditures and outcomes than do differences in insurance coverage. Sadly, our policy analysts and health reformers have failed to address the dysfunctional outcomes

created by the uniquely American practice of independent physicians working in hospitals. The self-employed medical staff is the figurative elephant in the living room; it causes serious problems that will persist until all parties are willing to create a new and more functional relationship.

Economic Nonsense

From an economic perspective, giving key workers a free factory without an obligation to work for the good of the organization that owns the factory is a prescription for market failure. Outcomes will make even less economic sense when the professional work force can maximize its income or achieve other objectives by playing one factory against another.

Imagine the damaging impact on corporate America if key employees could work simultaneously for more than one competing company. The conflicts of interest would be enormous, as workers maximized their returns by playing one company against another in the same marketplace. Numerous laws exist to prevent such economic abuses. Further, from the governance perspective, a board of directors is obligated to ensure conflict-free internal alignment to maximize return on corporate assets, not workers' incomes.

Health care is the exception to this basic rule of economics and business, both in comparison with other American industries and in comparison with the hospital-physician relationship in other countries that produce healthier populations with fewer resources. Current efforts to reform health care in the United States by replicating other countries' social contracts—that is, making health care a right—are unlikely

to be successful unless hospitals employ their medical staffs first. Dramatic changes are needed on both the demand and the supply sides of the medical marketplace.

Moving Forward Without

Looking Backward

The counterproductive misalignment of economic incentives on the supply side is not the fault of anyone currently on a hospital leadership team or medical staff. Today's problematic relationship was established nearly a century ago, and it made sense at the time. However, circumstances have changed dramatically. Both parties are being pulled down by the wasteful consequences of a zero-sum game in today's resource-limited marketplace. Creating a workable alternative will be a challenge, but protecting the status quo will preclude desired reforms.

To improve economic performance and social welfare—the ultimate goals of health reform—all parties must adopt a strategy of employing hospital medical staffs by a specific time. (To launch discussion and create a sense of urgency, I propose 2015 as the deadline.) A government mandate is unnecessary, and probably undesirable. Government incentives, on the other hand, might be helpful if resources are available. Future-focused organizations will see the need to take action as a matter of economic self-interest, because business as usual augurs well for no one.

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Many physicians will strenuously object to this essential restructuring of the hospital-medical staff relationship for two reasons.

First, they will claim *incorrectly* that physicians cannot practice good medicine if they are subject to the constraints of employment. To the contrary, extensive experience at home and abroad proves that excellent medical care can be provided by employed physicians. Many of the best hospitals in the United States, civilian and military, employ all the physicians on their medical staffs.¹

Second, many physicians will claim *correctly* that hospitals generally do a poor job managing physicians. Hospitals made serious mistakes when they purchased medical practices in the 1990s and they need to approach physician employment very differently this time, beginning with widespread use of qualified physician executives (including the CEO).

The way we reimburse for services also explains major inefficiencies of American health care, but that's the subject for another column. For purposes of this analysis, the inherent competition between hospitals and self-employed medical staffs is a medical and economic problem that can be cured only by well-managed employment of all physicians who work in hospitals. Reformers need to revise their views and plans accordingly. ☎

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¹ For specific examples, see Bauer, J.C., and Hagland, M., *Paradox and Imperatives in Health Care*, New York: Productivity Press, 2008.

Optimal Capital Structure: A Mix of Debt and Equity

In the Winter 2007 issue of *Strategic Financial Planning*, we defined 10 critical financial questions that hospital boards and senior management should address. To this point we have covered six of the 10 questions:

1. What is my firm's overall financial health?
2. How much cash should our firm carry?
3. Is our present level of investment reasonable?
4. How much profit should we target?
5. Are our costs too high?
6. Are our managed care contracts reasonable?

In this issue, we will focus on defining the mix of debt and equity for a hospital.

Conflict among hospital board members often peaks during times when sizable capital financing issues are being discussed. Two major opposing viewpoints frequently will polarize the discussion. One group of board members approaches the subject from a purely financial perspective and is almost exclusively concerned with the impact on the hospital's present bond rating. Another group sees proposed bond financing from a need perspective and is less concerned with financial impact. Neither approach is wrong, but neither is right, either. In reality, a blend of both is desirable.

What Should Your Capital Structure Be?

Many hospitals have target capital structures based on bond rating criteria such as long-term debt-to-capital ratios. Ultimately, however, the issuance of debt in either a taxable or tax-exempt environment revolves around the central theme of finance, which is "risk versus return" analysis.

In the taxable world, the primary objective is maximization of shareholder wealth, often measured by return on equity (ROE). Incurring additional debt clearly raises risk and must be accompanied by an improvement in the ROE. In capital asset pricing models, the risk is split into industry risk and organization risk, which is based on financial leverage. The higher the degree of financial leverage, the greater the financial risk and the greater the cost of equity capital.

The majority of hospitals in this country are not taxable enterprises, and the traditional risk-return analysis is not immediately applicable to their capital financing decisions. The element of risk is still critical in the analysis, but the assessment of return can be difficult. Ultimately, we believe the measurement of return in a tax-exempt organization is linked to achievement of mission. Furthermore, we believe that the primary element of mission for most tax-exempt hospitals is related to community need: the provision of high-quality, needed medical services to the community where the hospital is located. Other missions such as teaching and research may come into play for academic

Capital Investment Analysis Framework

Community Need	High	Samaritans	Stars
	Low	Dogs	Cash Cows
		Low	High
		Return on Investment	

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