Pitfalls and Problems In Physician Integration

BY CURTIS S. ROBERTS

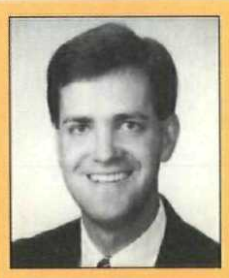
After working for several years to develop a fully integrated healthcare delivery system and watching other integration efforts from the sidelines, I have concluded that the vast majority of such efforts taking place across the United States are destined to fail. Why? Because most organizations pursuing integration fail to consider two fundamental questions:

• **How will the integrated organization deliver better value to the customer?** If it does not deliver better value to the customer, the integration process has created nothing of value and the new organization is not sustainable in the long run.

In considering this first question, an organization must make tough choices about the types of incentives that must exist in compensation programs, make hard decisions about the mix of physicians who should be involved, and must be willing to invest in physician leadership.

Doctors with the skills, training, and experience to manage a complex business organization like an integrated delivery system are worth their weight in gold. Unfortunately, doctors who could make truly effective leaders are few and far between. Many physicians lack the training and experience of making large-scale business decisions to successfully step into leadership positions. Thus healthcare providers have an obligation to provide potential physician leaders with opportunities to learn how to lead in a large, complex organization.

• **What is required to form an organization that will be lasting, robust, and satisfying to the physicians who are becoming a part of it?** Some organizations embarking on integration seem to believe their future is secure if they have a network of physicians locked up and committed to their organization, since those physicians supposedly cannot just walk away and leave. Organizations that simply throw money at doctor groups to get them integrated as quickly as possible will spend the next decade dealing with the unfortunate fallout.



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Pitfalls to Avoid

While considering these two fundamental questions, organizations also must be aware of pitfalls to avoid as the integration process evolves.

Culture When most people talk about integration, they are really talking about two forms of integration—horizontal and vertical—happening at the same time. Horizontal integration occurs when physician groups combine, and vertical integration occurs when combining physician groups join another organization—typically, an acute care provider.

Attempting horizontal and vertical integration simultaneously creates several cultural problems:

• *Pace.* Small physician groups run entirely by physicians are typically entrepreneurial and fast moving. When they integrate vertically with a large organization that moves at a slower pace, it can drive the physicians crazy. The solution is not for physicians to adapt to our way of doing business, but for us to adapt to theirs.

• *Size.* Doctor groups do not easily combine. They are usually separate for good reasons—personalities, history, economic incentives, and other issues that have helped fragment medicine into small groups. For many physicians who find the very thought of being part of a large groups repulsive, joining one is probably ill advised. Thus integration efforts may have to start small: Success on a smaller scale beats mediocrity on a grand one.

Partnerships with Specialists An important pitfall is the belief that, economically speaking, integrated delivery systems would be best off ignoring the high-ticket specialist. Proponents of this myth say that primary care physicians should be the essential part of the strategy, not only because of their limited numbers, but also because they control the patient flow in a managed care environment. These proponents argue that the overabundance of specialists in this country makes it possible to obtain their services more economically by contracting on the open market than by forming

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long-term partnerships.

We have a glut of heart surgeons in the United States, the argument goes, so it is foolhardy to form a partnership between a group of heart surgeons and our delivery system. Instead, the argument continues, we ought to have heart surgeons bid against each other to get the cheapest services.

This logic is flawed because it assumes that the service we are buying is a commodity, and that a heart surgeon in Seattle is the same as a heart surgeon in Portland, with equally acceptable products. I would counter that we will succeed only by forming stable partnerships with physicians across the entire spectrum of care. These partnerships must be committed to continual improvement of care so we are performing the service more cost-effectively and better than anyone else in the marketplace.

In that sense, heart surgery is not just heart surgery. If we, in partnership with our heart surgeons, can find a way to get patients out of the hospital two days quicker with 20 percent fewer deaths, we have built into our organization a sustained advantage. Those who are contracting with physicians on the open market will never be able to accomplish that. The U.S. auto industry learned this lesson the hard way in its relationships with suppliers. Healthcare should avoid the same trap.

The Integration Continuum Another pitfall is the belief that any kind of formal relationship with doctors is better than no relationship at all. Integration falls along a continuum, and most people agree that moving to the most integrated end of the continuum provides a better chance of actually creating better value. (Although conventional wisdom is beginning to challenge this perspective, I am still convinced it is correct.)

Some have a mistaken belief, however, that if we cannot become fully integrated, we are better off at least moving to some point along the continuum. I would argue that some of the earlier or less aggressive models in the integration continuum are so inherently bad in their design they are more likely to spoil the chances of achieving full integration than of fostering progress.

Sense of Urgency Another mistaken belief about integration is that everybody understands that change is coming and is waiting in an increasing state of readiness to move on to new ways of organizing and delivering medicine in America. I believe this is far from true. The need for change must become *real* and *personal.* As Adlai Stevenson once observed, people can't read the writing on the wall until their backs are up against it.

Thus the single biggest impediment to change is the lack of a sense of urgency that change is necessary. It takes far longer than one would expect to "sell the problems" that integration is expected to solve, such as lack of competitiveness, declining premiums, and the need to contract effectively with a consolidating and more powerful insurance industry. We need to use real live data from our markets to show just how serious these problems are. And in many respects the most compelling of those problems are personal ones—things like income and autonomy and personal and professional satisfaction. Those who try to integrate to address these very real problems without first creating a sense of urgency are just spinning their wheels.

The Tough Questions

When pursuing integration, organizations will benefit from both a process and a content standpoint by considering these issues. Those unwilling to tackle the tough questions will find their integration efforts to be a costly and wasted exercise. □

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