remarks

The Pendulum Swings

With demand for specialists on the upswing, hospitals and payers will increasingly value their relationships with these physicians.

BY NIELS KRONBORG ANDERSEN

Constant change is the only constant we can be sure of in health care. This certainly holds true with respect to physician demand in the market place. The volatility and uncertainty within the health-care industry of the past several years have created wide swings in strategy throughout the industry. These wide swings of the pendulum can easily result in reactive decision making as opposed to proactive decisions. The inability to fully understand the long-term impact of short-term decisions can be problematic.

For the past seven to eight years "all the buzz" has centered around the primary-care providers (PCPs). Creating new PCP residency programs was the "thing to do" for many hospitals and universities. At the same time, many specialty training programs were downsizing or being shut down completely as a result of apparent oversupply of specialists and the fact that more graduating medical students and residents have been choosing primary-care specialties. General surgery, anesthesiology, and pathology were perhaps the hardest hit, but others had the same fate.

This trend has carried over into the relationships between hospitals and practicing specialists. As hospitals have been busy building PCP networks, they perhaps have not addressed the needs of the specialists as well as they could. Now hospitals are beginning to factor the true value of the specialist back into their overall strategy. The pendulum is swinging back to favor the specialist again, or so it is beginning to appear.

Perhaps the market over reacted to the reported need for primary-care physicians. This 'reactive' response to perceived future demand, perhaps based on less-than-qualified articulated demand analysis, may place undo burden on the industry in the future. Did the futurists factor in the demographic profiles of the current supply of specialists or simply estimate actual current practicing spe-

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cialists? Specialists are obviously getting older and are considering retirement earlier in their careers than ever before. One can speculate that while many resources have been deployed by hospitals to help the primary-care 'gatekeepers' through the trials and tribulations of managed care, specialists have been largely ignored and left to figure out the business of health care on their own. As a result, many have decided to retire early, getting rid of the headache all together.

If it turns out the industry overreacted,(thereby creating a surplus of PCPs and a deficit of qualified specialists beginning in the near future), then certainly two of the primary drivers for this trend were the late health-care reform movement and the rise of managed care. But perhaps all segments of the health-care continuum should share the blame, including:

- Teaching and non-teaching hospitals for poor planning or lack of foresight,
- Medical schools for pushing students towards primary care,
- Medical students when selecting their residency programs,
- Insurance companies with their effort to direct and manage care,
- The government by neglecting to manage the trend it started,
- The media for sensationalism, and finally,
- The patients or general public for being followers.

Rising need for specialists

Perhaps as a result of these missteps on the part of the health-care publics, the need for specialists is on the rise in the marketplace. In fact the need for specialists is reaching the point where the supply is beginning to be unable to meet the demand. Specialists in general surgery, anesthesia, and even pathology have found themselves in demand in recent months. In addition to making recruitment efforts more difficult, the price has naturally also gone up for these physicians. Only two years ago these specialists had an extremely difficult time finding work. This change is seen as a leading indicator of what will come for other specialists as well.

At a recent meeting of the Association of Staff Physician Recruiters, (ASPR, an association of hospital-employed, in-house recruitment professionals) it was evident that most of the organizations throughout the country were seeking greater numbers of specialists

On the other hand, primary-care physicians are finding themselves in lower demand. Groups, whether they be multi-specialty or primary-care based, are reaching their size limit with respect to PCPs. The demand for pediatricians has decreased in many markets as has the demand for family practitioners in the more mature markets.

The Next Generation

The physicians responsible for the greatest portion of a hospital's revenue and profit are the specialists. It is true that primary-care providers direct much of the referral care, but those referrals are also based on the availability of services and specialists. Specialists also play a dominant roll in reducing LOS and costs, and improving outcomes—critical elements for hospitals when trying to manage managed care.

Peter Heckathorn, the senior vice president for strategic services at Sacred Heart Health System in Pensacola Florida, suggests: "As the gatekeeper model for health care wanes due to health-care plans recognizing that the specialists are the guys who can really control the costs and deliver the critical pieces of care, there will be an upswing in demand for highly qualified and highly responsive specialists." Payers are as interested in controlling costs as hospitals and for the same reasons, reducing cost and increasing profits.

Even for the larger PCP groups who are independent of hospital ownership, it will become increasingly important to secure strong relationships with specialists. Many PCP groups simply look to negotiate provider/referral relationships with specialists and are not interested in having them actually join the group. That may need to change.

PCP groups will likely start hiring specialists just like the specialist groups hired PCPs, except PCPs will want to have the control this time. Having closer ties with specialists by being in the same group can be used as leverage points when contracting with payers, outside specialty groups, and even with hospitals in global risk sharing. It can also serve in a customer satisfaction role by having better access to and control of referrals, providing convenience for patients.

Hospitals will likely be the largest buyer of specialist practices in the future. The primary drivers will probably be the physicians themselves and will be due to the continuing desire to:

- further secure market share
- increase economies of scale of the employed PCP networks the hospitals may already have
- meet the needs of graduating specialists who are seeking employment with larger groups with an established referral group in place
- maximize cost control for inpatient and outpatient services
- maximize financial and market security for the specialists
- specialists' desire to sell their practices

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to the highest bidder

- specialists' desire to reduce the business burden of daily practice management.

Though partnership tracks for new specialist recruits remain fashionable today (probably because there are few alternatives), as hospitals increasingly acquire specialty practices, specialists are expected to prefer employment situations. Today, most PCPs prefer to be employed with a large group which can provide financial security, reasonable autonomy, and a normal lifestyle. These factors will ultimately drive specialists to seek the same option.

Specialists face the same woes PCPs face regarding running a practice—lower reimbursements, contracting issues, hiring and firing staff, business accounting mechanics, and the like. As more and more practice management services are made available to specialists via employment and Management Services Organization (MSO) models, specialists will want to participate with organizations which will reduce their headaches of managing the business alone.

Income and practice value will be maximized if physicians are with the right group. The right group is defined as an entity within which a physician is able to participate in the strategic and operational decisions while earning competitive, fair, and equitable wages. Physicians and administrators should share a vision of the future of their business enterprise whether or not physicians and hospitals are considering an employment model. Buying and employing physcians is not always the best answer; forging strong partnerships should be the ultimate goal whatever the methodology.

Hospital expectations

Hospital-owned groups should have the understanding that the physician practice budget should be designed to break even. Any organization that thinks there is a direct profit potential in a physician practice is mistaken. Let's look at the logic path. To build a successful group, the group needs to be able to recruit and retain the very best possible quality physicians. These physicians are the backbone of the organization and will enable marketing, contracting, and operations to create the competitive advantage the group needs to secure market share and financial security.

Having the best costs money and the compensation packages paid to these top quality physicians must be competitive and comparable to what they could earn elsewhere. If these top-of-the-line physicians were in solo practices, they would take home everything after the operating overhead has been paid. Thus, in a hospital-owned practice, after all the overhead and competitive physician wages have been paid, normally little profit remains. Their income potential is certainly one of the major criteria on which physicians gauge an opportunity.

One concern hospitals will have is the perceived potential financial loss of continuing to employ physicians. Unfortun-ately, recent studies suggest that on average, hospital-owned physician groups loose between $50,000 and $100,000 per employed physician per year. However, if part of these losses include practice start-up investment capital, it may not be fair to call that 'growth investment' a loss to the physician, particularly if the need to grow was predicated on the desire by the hospital to gain or secure hospital market share. If the group were left to its own devices the physicians may not have wanted to make the investment. As hospitals continue to provide capital to the development of physician networks loyal to the hospital, they must begin to differentiate between expense and investment capital. The hospital should carry this investment burden and risk, not the group. The hospital should allocate those funds from the profit it projects as a result of the business generated to the hospital from its loyal physician network.

Hospitals should expect to earn their money the old fashioned way—from inpatient and outpatient services. If hospitals intend to employ physicians they should provide the growth or start-up capital the group will need to reach financial self sufficiency.

The future

What does all this mean for the future? What the market will do and what should be done are the big questions. It may be easier to try to answer 'what is the meaning of life?' than to know the future of the health-care market. The bottom line is there is no one single answer, and the answer which would be correct today may not be applicable tomorrow. The best advice for everyone in the industry is perhaps to ask great questions continuously and often to accomplish continuous improvement. It is uncertain if physicians and administrators will ever be able to reduce the wide swings of the pendulum with respect to physician demand. It is clear though, that PCPs, specialists, and hospitals need to work together. And the next few years may financially favor the specialists again. ■

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