As more physicians and their practices form relationships with hospitals and health systems, a growing number of leadership and strategic issues are bubbling to the surface.

Health systems are employing physicians in all specialties as at no other time in history. In the 1990s, hospitals began employing primary care physicians as a strategy to reap the reported advantages in a new capitated environment. Hospitals believed that employing physicians by buying their practices and integrating them into the hospital environment would be a relatively easy task. The majority of those strategies ended in failure, and hospitals later divested those same practices.

In addition, several for-profit companies were created to buy up private practices. But once economies of scale were realized, profits eroded, and the expected return on investment did not materialize. A majority of these companies have since withered away.

The Numbers Tell the Story
The number and size of hospital-owned medical group practices have been increasing steadily during the past decade, according to a demographic profile of its medical group members compiled by the Medical Group Management Association (MGMA) in December 2010. At the time of the survey, 11.6 percent of 8,744 medical groups belonging to the MGMA were hospital-owned, and 80.7 percent were physician-owned, as shown in Table 1. (The remainder were owned by an assortment of organizations, including universities, HMOs, and government entities.) To put these values in perspective, the percentage of hospital-owned practices grew from 8.3 percent in 2003 to 11.6 percent in 2010—an increase of 40 percent—while the percentage of physician-owned practices dropped from 83.2 percent to 80.7 percent during the same period, a decrease of 3.0 percent (Table 1).

Additionally, the number of doctors in hospital-owned practices is proportionally much larger than the number in physician-owned practices. Although, as noted above, physician-owned practices accounted for 80.7 percent of all MGMA member medical groups in 2010, they had only 44.6 percent of the doctors. By contrast, hospital-owned practices accounted for 11.6 percent of the medical groups but...
28.1 percent of the total physicians (Table 2).

Similarly, although some physician-owned practices are very large, in general, hospital-owned practices are much larger. The average MGMA member physician-owned practice had 19.5 FTE physicians in 2010; the average hospital-owned practice, at 85.8 FTE physicians, was more than four times as large (Table 3).

Tables 1, 2, and 3 present a complete description of MGMA member medical group demographic information for 2010 and 2003 (the oldest data available) and the percentage change over this seven-year period. Although the survey was not intended to measure hospital ownership of medical groups, the changes in MGMA’s membership profile parallel national trends, which show a significant increase in hospital ownership of medical practices.

What trends are behind the increase in physician employment? Economic, personal, and competitive issues all play a part.

**Economic Issues**
The economic reality of the past ten years is that the physician’s overhead—the cost of having a medical practice—has increased every year. Total operating costs per FTE physician have been rising rapidly over the past several years. In 2003, multispecialty groups reported total operating cost per FTE physician of $349,090, or 60.30 percent of total medical revenue (Medical Group Management Association 2004). In 2010, total operating cost per FTE physician increased to $475,749, or 62.64 percent of total medical revenue (Medical Group Management Association 2011). This increase has occurred at a faster rate than increases in reimbursement—a recipe for disaster.

### Table 1. MGMA Member Medical Groups by Ownership

<table>
<thead>
<tr>
<th>Ownership</th>
<th>% of Groups 2010 (N = 8,744)</th>
<th>% of Groups 2003 (N = 7,397)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-owned groups</td>
<td>80.7%</td>
<td>83.2%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Hospital-owned groups</td>
<td>11.6%</td>
<td>8.3%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Other ownership (e.g.,</td>
<td>7.7%</td>
<td>8.5%</td>
<td>-9.4%</td>
</tr>
<tr>
<td>universities, HMOs)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### Table 2. Physicians in MGMA Member Medical Groups by Ownership

<table>
<thead>
<tr>
<th>Ownership</th>
<th>% of Physicians 2010 (N = 212,112)</th>
<th>% of Physicians 2003 (N = 181,040)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-owned groups</td>
<td>44.6%</td>
<td>43.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Hospital-owned groups</td>
<td>28.1%</td>
<td>17.0%</td>
<td>65.3%</td>
</tr>
<tr>
<td>Other ownership</td>
<td>27.3%</td>
<td>39.3%</td>
<td>-30.5%</td>
</tr>
</tbody>
</table>


### Table 3. Size of MGMA Member Medical Groups by Ownership

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Mean Number of FTE Physicians 2010</th>
<th>Mean Number of FTE Physicians 2003</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-owned groups</td>
<td>19.5</td>
<td>16.4</td>
<td>18.9%</td>
</tr>
<tr>
<td>Hospital-owned groups</td>
<td>85.8</td>
<td>64.3</td>
<td>33.4%</td>
</tr>
</tbody>
</table>

Many physicians see only two ways to survive in today’s environ-
ment: merge with another practice and form a larger group, thus taking
advantage of economies of scale and enhanced revenues; or join a hospi-
tal and become a hospital employee, allowing the hospital to assume
financial responsibility for their practice and overhead.

**Personal Issues**
A major advantage enjoyed by hospital leaders seeking to employ
physicians today is that the current generation of physicians does not hold many of the values and beliefs of the previous generation. Many physicians in their fifties and older came from a generation that believed being an independent physician was the preferred model, leading to ultimate success. As a physician, you were a small-business owner and had total control and authority over your medical practice. You also had all the headaches associated with running your own business.

Many of today’s physicians in their thirties and forties have seen the lifestyle their older mentors have had to endure and are choosing a different lifestyle, one that offers a better quality of life and more protected time. This often means that physicians are looking to work fewer clinical hours, take less call, be in a larger medical group practice, and not have all the headaches associated with being a small-business owner. Physicians understand that getting what they want out of their personal lives and making the salary they desire means they may have to be employed by a health system or hospital. Many physicians are willing to make those sacrifices, however defined, to ensure they are meeting their personal goals.

**Competitive Issues**
Competitive issues for hospitals can also be classified as political issues. Some physicians have no strong desire to join a hospital or merge with another medical practice until someone else in their market forms a relationship with a hospital. A physician in one medical community told me he is not interested in joining the hospital until it buys other practices in the community. At that point, he believes he will no longer be able to compete with the hospital’s marketing efforts and support of those practices because of its deeper pockets, its ability to negotiate rates with insurance companies, and its greater ability to weather financial losses—much greater than he has in an independent practice.

**Implications for Hospital Leaders**
If your organization is thinking about employing physicians, focusing on the strategic questions below will help your organization develop a climate of trust and open a productive dialogue among physicians and hospital leaders.

Does employing physicians fit with your organization’s mission, vision, and goals? If the answer is yes, educate your governing board as to the reasons for employing physicians. Emphasize that success will be measured by a number of factors, including short-term and long-term measures, not simply profit-and-loss statements.

Is your organization willing to have a physician leader or leaders be an integral part of the management team? In today’s healthcare environment, it is crucial

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**Figure 1.** Physician–Administrator Dyad

[Diagram of Physician–Administrator Dyad]

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Many physicians see only two ways to survive in today's environment: merge with another practice and form a larger group, or join a hospital and become a hospital employee.

to involve physicians—specifically, a physician executive—in hospital decision making and strategic planning. Hospital leaders who cannot embrace this management philosophy will be marginalized.

Are reporting relationships appropriately structured? The most successful systems are those in which physician–administrator dyads are spread throughout the organization, from inpatient service line management to outpatient medical group management. The dyad leadership model often helps to address issues of trust and serves as a bridge to stronger relationships while aligning the cultural, business, and clinical aspects of physician–hospital integration.

It is important for medical groups to select a physician executive—who can be either a full-time employee or a physician who maintains a clinical practice—to lead the physician entity, along with a non-physician executive who is trained in medical group management. These two leaders are hired and empowered to run the physician medical group(s). Both executives should be employed by the hospital system and dedicated to the leadership and management of the physician enterprise. The nonphysician executive selected to co-lead the medical group(s) should be experienced in running a medical group practice; hospital experience alone is not sufficient.

Depending on how the physician entity is legally established, the scale of the organization, and the number of physicians employed, these two executives could report to the CEO, the chief operating officer, or another senior health system executive or to a board of directors (Figure 1). While the CEO of the health system or subsidiary board (depending on the organization’s corporate structure) is the ultimate authority by way of organizational hierarchy, the employed physicians within the division report to the medical group physician executive, while the nonphysician managers report to the medical group administrator.

Is the CEO accessible? Do not put too many layers of management between the hospital CEO and the physicians. Employed physicians will not want to deal with middle managers or junior-level executives. Physicians should be only one to two tiers or layers away (at a senior vice president level) from the CEO, and the CEO should communicate with this executive regularly.

Does your organization have sufficient human resources expertise to manage the physicians and their practices? Competent medical practice office managers with medical group management experience are essential; hospital service line experience is not sufficient.

Does your organization have the IT and billing systems needed to manage this product line? From a systems perspective, it is important for your organization to have the expertise to bill and collect for physician services. It is also important for the billing and practice management system to be integrated with the electronic health record (EHR). Efficient integration of the inpatient and outpatient systems is paramount. Having a strong inpatient system and a weak practice management and EHR for the medical practices will only frustrate physicians and make them inefficient.

Other key success factors. Physician compensation plans should have incentives aligned with the organization’s goals and, until a new form of reimbursement is established, should be based in part on productivity. Other key ingredients are having responsive governance and management systems in which other physicians participate in decision making and administrators and physicians share a willingness to help build a sustainable physician–hospital integration strategy.

References