

HOSPITAL-PHYSICIAN JOINT VENTURES: A PROMISING PARTNERSHIP?

INTRODUCTION

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This year and for the second time, the McDonald Merrill Ketcham Award and Lecture were held in conjunction with a symposium convened by the *Indiana Health Law Review*. This year's topic was "Hospital-Physician Joint Ventures: A Promising Partnership?" Professor James F. Blumstein, the recipient of the McDonald Merrill Ketcham Award, opened the symposium with his lecture entitled "Of Doctors and Hospitals: Setting the Analytical Framework."¹

The relationship between hospitals and physicians is extraordinarily important. Hospitals need physicians to order the admissions and hospital services on which hospitals depend for their economic survival. Physicians, particularly those in more intensive specialties, need hospitals as sites to deliver their professional services. Neither can survive without the other. As Professor Blumstein observed at the opening of his Article, "The issues surrounding the movement toward integration of physician services and the institutional and economic interests of hospitals raise some of the most critical, delicate, and longstanding health policy and law issues confronting analysts and policymakers."²

In his Article, Professor Blumstein identified several issues implicated in the integration of physicians and hospitals. To what degree do economic considerations factor into medical care decision making? What is the appropriate role of physicians, as expert autonomous professionals, in medical care decision making and what are the appropriate legal, institutional, and regulatory structures to shape that role? His Article goes on to delineate expertly how legal obligations and financial responsibilities have redefined and reshaped hospitals and how hospitals have thus moved away from the professional-scientific paradigm that informed hospital management in the 1960s and 1970s. Professor Blumstein extols the need for regulatory flexibility in approaching new economic relationships between hospitals and their physicians to respond to new circumstances in the marketplace.

Following Professor Blumstein's superb lecture was commentary by some

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¹ See James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 *IND. HEALTH L. REV.* 209 (2007).

² *Id.* at 211.

of the most knowledgeable health lawyers and professionals in the state and, indeed, the nation. Greg Pemberton, the partner in charge of the health law practice at the law firm of Ice Miller and past chair of the ABA's Health Law Section, expertly moderated the panel. The discussion focused primarily on ways in which legal and business relationships between physicians and hospitals could be made more efficient, economical, and profitable for both physicians and hospitals.

Norm Tabler, Senior Vice President and General Counsel of Clarian Health Partners, claimed that the primary cause of the increasing dysfunction of the traditional hospital-physician relationship is "disaggregation." In episodes of medical care, particularly when it involves a hospital, there is a complete disaggregation of the interests of hospitals and physicians. The various interests are not aligned, but competitive and conflicting.

Steve Pratt, a partner at the law firm of Hall, Render, Killian, Heath & Lyman, was asked to describe different models for the integration of hospitals and physicians, short of total integration through physician ownership of hospitals. He also agreed that, in current relationships between physicians and hospitals, there is a "disconnect" between the authority to make decisions and the consequences of the decisions on the economic side.

Dennis Pippenger, M.D., recounted his experience establishing a management company at a local hospital that was jointly owned by the surgeons and other surgical specialists with the hospital. This joint venture now manages all the surgical operations at the hospital and employs all the surgery department employees. He pointed out the numerous ways in which this new company was successful, mainly through the alignment of financial interests of the hospitals, providers, and staff.

Michael Finnerty, Vice President of Kaufman Hall & Associates, Inc., talked about physician efforts to make medical practice more profitable. He first observed that the force driving physician practice acquisitions in the 1990s was a perception among physicians that they were not getting enough of the health care dollar. He recounted the experience of so-called physician practice management companies in the 1990s and how they were attempting to reorganize medical practice to reap greater financial rewards for the owner physicians.

Greg Pemberton commented on how these physician practice management companies were the darlings of Wall Street in the early 1990s. All they had to do was grow so that they could raise more capital. However, the model disintegrated because the management companies were unable to return sufficient dollars to the physician employees who had owned the practices the companies acquired. Growth and accounting tricks alone were not enough to keep Wall Street happy, and so these companies hit a wall. Only the single specialty management companies survived.

Mike Finnerty noted that these single specialty management companies are highly dependent on very expensive equipment and technologies. The successful combination for these for-profit medical corporations seems to be private capital, management expertise, and a medical specialty organized around

an expensive technology. An example of this phenomenon is US Oncology, which now controls a very large proportion of the oncologists in practice in the United States.

Steve Pratt then commented on the impact of hospital contracts with physician groups when they purchase physician practices in a given community. The hospital locks up local physicians with non-compete clauses in their contracts, which prevent these physicians from providing services to, have ownership in, or receive financial compensation from any other competing group. This state of affairs, Steve Pratt observed, is somewhat inconsistent with the theory that underlies the nonprofit community-based hospitals – to serve the community. While these hospitals have an obligation to remain financially healthy, tying up physicians with non-competes in a way that is good for the hospital but not good for the community is inconsistent with the theory of tax-exempt organizations. Yet this happens all the time, and it is a barrier to getting things done.

In closing, it might be appropriate to revive what Professor Blumstein has called “[o]ne traditional view” of hospitals and the medical profession that “suggests that the very introduction of economics into medical care decision making corrupts medical judgment and therefore should be avoided.”³ Today’s relationships between physicians and hospitals are all about maximizing financial returns from both types of providers. Yet the financial returns for all providers are derived primarily from health insurance benefits for individual patients and/or the personal funds of these patients. Pricing of services is based on the assumption that most patients, particularly recipients of expensive, technological intensive care, will have health insurance. Further, a third of the insured – who customarily are greater users of health care services – are insured through public health insurance programs.⁴

What is rarely discussed in the debate over physician-hospital relationships is the fact that they operate in the context of colossal market failure. Over sixteen percent of the U.S. population has no health insurance and even more have inadequate health insurance.⁵ And costs of health care services are rising thus threatening the ability of individuals and the sponsors of their health insurance – be they private employers or public programs – to continue providing affordable health care coverage.

The current situation is unsustainable. Take Indiana as an example. According to the analysis of an Indiana University faculty work group with whom the State of Indiana has contracted to develop options for health care reform for Indiana,⁶ Indiana’s health care sector is headed for disaster. In 2004, Indiana

³ *Id.* at 211-12.

⁴ CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & CHERYL HILL LEE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 (U.S. Census, Consumer Population Reports, Aug. 2006), at 21 fig. 6.

⁵ *Id.*

⁶ See INDIANA UNIVERSITY HEALTH CARE REFORM FACULTY WORK GROUP, A FRAME-

spent 14.4% of its Gross State Product (“GSP”) on health care (compared to 13.3% nationally). Between 1995 and 2004, personal health care expenditures in Indiana increased 83% while GSP increased only 55%. If these trends continue unchecked, health care expenditures would constitute half the state’s economy by 2035. Further, between 2000 and 2004, Indiana experienced the second greatest drop in private health insurance coverage in the nation. Insured Indiana employees are assuming an increasing share of the costs, with their portion of premiums increasing at more than seven times the rate of the increase in wages. Indiana’s rate of medically-related bankruptcy is the highest in the nation. This is market failure.

Until health care providers and private health insurers can figure out how to design a market for health care services that assures access for affordable health care services either through direct purchase or affordable insurance, it is inappropriate to focus the debate on how to align economic incentives for hospitals and physicians to maximize their profits. No other market in the U.S. economy – except defense and possibly education – is so highly dependent on public funds for the economic returns to its producers. Financing and delivering health care services through for-profit structures, which capture excess revenues as profit for shareholders rather than funds to reinvest in expanding access and reducing costs of public programs is problematic. The expectation of profit is only appropriate when the economic actors in a market are able to provide goods and services at affordable prices and without public subsidies for all who seek to purchase those goods and services.