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# Hospital-Physician Relations: Cooperation, Competition, Or Separation?

Economic pressures are creating an adversarial climate in some areas and pushing physicians and hospitals together in others.

by **Robert A. Berenson, Paul B. Ginsburg, and Jessica H. May**

**ABSTRACT:** Because many services performed in hospitals can safely and conveniently be performed in ambulatory settings, physicians have become owners of entities directly competing with hospitals for patients in a new medical arms race. Hospitals and medical staff physicians face growing tensions as a result of physicians' growing reluctance to take emergency department call and the consequences of hospitalists replacing physicians in the care of inpatients. Although there are increasing expectations that health system challenges will lead hospitals and physicians to collaborate, in many markets the willingness and ability for hospitals and physicians to work together is actually eroding. [*Health Affairs* 26, no. 1 (2007): w31-w43 (published online 5 December 2006; 10.1377/hlthaff.26.1.w31)]

PHYSICIANS TRADITIONALLY HAVE BEEN relatively independent of hospitals and have used them as “workshops” in which to carry out their professional services.<sup>1</sup> In the prevailing medical staff model, physicians and hospitals did not have a typical market relationship: They neither bought services from nor competed with each other. Rather, physicians and hospitals informally exchanged physicians' use of the hospital's facilities for carrying out responsibilities, such as serving on quality and utilization review committees and taking emergency department (ED) call, as obligations for having medical staff privileges.<sup>2</sup>

As a response to managed care in the 1990s, new organizational arrangements between physicians and hospitals were initiated but then largely abandoned as the use of capitation to pay providers began a rapid decline by the late 1990s that continued into the new century. Hospitals began to shift their focus from building physician-hospital organizations (PHOs) and related organizations to building stronger relationships with specialist physicians, to benefit from high-margin,

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specialized services and to try to avert potential competition with physicians in delivering outpatient services.<sup>3</sup> This has taken the form of new approaches by hospitals to branding, marketing, and providing services—called a “service-line strategy.”<sup>4</sup> Although closely affiliated specialist physicians are central to hospital-based service-line products, other less closely affiliated specialists are competing directly with hospitals by developing or expanding physician-owned specialty facilities of various kinds.

The new competition over service lines contrasts with findings from the 2000–01 round of the Community Tracking Study (CTS), at which time most physician-hospital activity focused around evolving models of affiliation between physicians and hospitals. By the 2005 round, however, it was becoming evident that market factors were threatening not only these new business-oriented affiliations but also long-standing collaborative relationships between physicians and hospitals.

Although competition over services was a main source of tension between hospitals and some physicians, there were other sources of conflict as well, such as physicians’ growing reluctance to take ED call. These developments were working in concert to threaten physicians’ long-standing orientation toward supporting hospitals’ social missions, including caring for the uninsured.

The confluence of forces threatens the long-standing assumption that physicians and hospitals share common interests. As succinctly captured by a hospital executive, “Doctors used to feel that in return for having the hospital as a place to care for their patients and earn income, they should contribute to the hospital, taking ED call, participating on committees, improving quality. Now they say to the hospital, screw you.... Many don’t even come to the hospital any more.”

Other developments are acting as a partial counterbalance to bring hospitals’ and some physicians’ interests closer together, such as the need to collaborate on service lines and respond to pay-for-performance (P4P) incentives to improve hospital quality. Further, physician-hospital competition is fierce in some sites and gentler in others; similarly, physician-hospital collaboration is also occurring differentially across the twelve CTS communities. As we describe in this paper, competition and collaboration are occurring concurrently in many of the sites.

This paper provides a snapshot of current hospital-physician relations across CTS sites. We first review findings suggesting that difficult relations with physicians have become more important for senior hospital management. We next describe thematic areas in which physician-hospital relations are evolving. Finally, we explore recent developments in important areas of common interest to physicians and hospitals and the variations on these developments across CTS sites.

## **Study Data And Methods**

The CTS has conducted site visits to the same twelve nationally representative communities every two to three years since 1996 to examine changes in the financing, organization, and delivery of health care. During Round Five, conducted dur-

ing January–June 2005, 1,008 semistructured, qualitative interviews were conducted in person and by telephone with major health care system stakeholders.<sup>5</sup>

We interviewed senior executives at two to four of the largest hospital systems or freestanding hospitals in each of the twelve markets, including chief executive officers (CEOs), chief financial officers (CFOs), vice presidents for planning, and heads of nursing; state hospital association executives; medical group executives; senior executives at two to four of the largest health plans and employers in each market; and others with perspectives on hospital-physician relations.

During Round Five, specific topics of analysis included hospital capacity constraints, specialty hospitals, P4P, and use of health information technology (IT). Respondents also were asked to describe major changes in the local market and providers' competitive strategies. Physician-hospital relations emerged as an important topic through study of the specific research areas, as well as through the broader reporting of overall market changes. Overall, 296 respondents, including hospital CEOs and chief medical officers, and single- and multispecialty medical group CEOs and medical directors, provided information on various aspects of hospital-physician relations.

Respondents also were asked to name the top three pressures faced by their hospital or by hospitals in their market. To identify trends in these responses, we compared responses to this question from Round Five with those from Round Three, conducted in 2000–01. We focused on responses to this question provided by hospital CEOs, given their broad perspective on the mix of pressures facing hospitals. For the few hospitals or hospital systems where CEOs were not available, we substituted responses from other senior executives.<sup>6</sup>

### **Hospitals' Perceptions Of Relations With Physicians**

Hospital-physician relations were perceived to be under greater strain in 2005 than in 2000–01. In Round Five, 46 percent of interviewed hospital or hospital system CEOs identified various aspects of relations with physicians as among the top three pressures their hospitals were facing. This percentage compares to the 64 percent who identified reimbursement issues and 43 percent who identified hospital staff (for example, nursing) shortages as major pressures.

The two major physician-related pressures specifically identified were competition with physicians over services (21 percent) and problems assuring physician coverage of the ED (11 percent). In contrast, in Round Three, only 15 percent of hospital CEOs described issues involving physicians as being among the top three pressures they faced. At that time, only 11 percent identified competition with physicians over services, and no one identified ED call as a major pressure.

■ **Service-line strategy.** Hospitals and physicians were engaged in a number of areas of overlapping interest, some providing an impetus for closer alignment and some leading to more competition among important large segments of the physician community and hospitals. One of the major themes in most CTS sites was competi-

tion to expand revenue, mostly in the context of service-line strategies that hospitals and physicians have been adopting in recent years.<sup>7</sup> Hospitals were competing by aggressively branding specialty services, such as heart, cancer, and orthopedic/spine centers. As part of the service-line branding, physicians often were emphasized in marketing materials and, in some cases, played major management roles in running the service-line products.

■ **Physician-hospital competition.** At the same time that some physicians were affiliating with hospitals in the service-line strategy, other physicians were aggressively competing with hospitals over services, sometimes for traditional inpatient services with stand-alone specialty hospitals and, more commonly, with ambulatory-based facilities, such as ambulatory surgical centers and imaging centers. Respondents identified a few factors that were encouraging physicians' entrepreneurial interest in competition over services: seeking additional sources of income, increasing consumers' expectations of "one-stop shopping" for physician services, and growing physician demand for control over their own work environment.<sup>8</sup>

■ **Purchasers' expectations.** Finally, private and public purchasers have had new expectations that hospitals would improve patient safety and quality of care through a number of initiatives, including the publication of comparative quality information and, more recently, by initiating P4P bonuses to hospitals that do well on specified quality measures.<sup>9</sup> The Centers for Medicare and Medicaid Services' (CMS's) Hospital Reporting Program, in particular, seems to have generated a positive hospital response to improve performance for conditions such as pneumonia and acute myocardial infarction (AMI).<sup>10</sup>

To improve their performance on quality and safety, hospitals need to engage physicians in measuring and improving quality. Hospital medical staff have responded positively to having a focused set of clinical priorities on which to work and to physician-specific performance data.<sup>11</sup> However, some hospitals have found that it is easier to work on these issues with a relatively small number of physicians who are employed than with a much larger medical staff made up of many physicians who now rarely—and reluctantly—participate in hospital activities.

The reorientation of physicians away from the hospital was captured by a physician group practice executive:

Traditionally, physicians have had a lot of loyalty to the hospital. They would actively go there to eat breakfast, for the camaraderie, etc. There is little loyalty now. Doctors don't take part in hospital governance unless they are forced to. They now treat the office as the central place. It is harder for hospitals without a loyal staff and when the hospital is no longer the center of the social structure for medicine.

## Competition Over Services

Respondents in all twelve sites commented on the growing competition between hospitals and physicians over services that had once been within the hospital domain. A Miami hospital executive commented, "We are in competition with our own medical staff." In the words of an Orange County physician, "Everyone

and their brother is opening an ambulatory surgery center [or] diagnostic center today. There is more and more shifting of services from hospital control to physician control.”

Although this shift in locus of service is ubiquitous, the intensity of competition between hospitals and physicians varied across the sites. For the most part, in Boston, Cleveland, and Seattle, which have large numbers of employed specialists, as part of either academic health center (AHC)-based faculty practices or multi-specialty group practices, hospital-physician competition over service lines has not had a broad impact. Further, in some sites, including Boston, Cleveland, and Little Rock, hospitals and physicians were both worried about shortages of physicians in important specialties and described a joint interest in attracting more physicians to the market.

On the other hand, in the markets dominated by relatively small, single-specialty practices, competition has become intense, as demonstrated by the findings on major hospital pressures described earlier. Even in Orange County, where there are well-established multispecialty medical groups and IPAs that accept capitation-based financial risk from insurers, the predominance of independent practitioners has led to the same kind of entrepreneurial physician activity as seen in the other communities where fee-for-service reimbursement prevails.

Although capitation provides disincentives for service-line development, there was enough and growing fee-for-service business in Orange County to stimulate service-line development as seen in most other markets. Further, some hospital respondents—for example, in Miami—considered the competition with physicians as actually more intense than with other hospitals in the community, pointing out that hospitals often served different populations in nonoverlapping geographic areas, whereas physician-owned facilities usually were located in the same service areas, sometimes within the shadow of the hospital. Consistently, medical group respondents often thought that hospitals, rather than other medical groups, provided the main competition for their services.

Although the issue of specialty hospital competition between community hospitals and physician-owned specialty hospitals has received national-level policy attention, more widespread competition is taking place over services that once were performed in hospitals but now can be safely performed either in specialized ambulatory facilities or in physicians’ offices. Some hospital respondents foresaw the role of new and anticipated technologies, such as cyberknives, gene therapy, and minimally invasive surgery, as accelerating the relocation of care away from hospitals. In the words of a northern New Jersey hospital respondent, “The physician piece of the market is huge. These disruptive technologies are rearranging everything.”

Ambulatory surgical centers (ASCs), often involving physician-ownership, are certainly not new. Yet respondents in many markets report that the reliance on ASCs as an important source of care has mushroomed in recent years because of

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physicians' entrepreneurial activity and, in some cases, such as Lansing, also because of perceived loosening of certificate-of-need (CON) restrictions and growing community acceptance of non-hospital-based care.

Respondents in a number of sites described a large out-migration of gastrointestinal (GI) endoscopies into dedicated ASCs or into the physician practices themselves.<sup>12</sup> Another area of intense competition is over advanced imaging services, such as positron-emission tomography (PET), magnetic resonance imaging (MRI), and computed tomography (CT) scans. Respondents in some sites, including Miami and Orange County, described the consolidation of individual practices into large single-specialty groups driven largely by the physician group's desire to have enough referral volume to support surgery and imaging centers.

### **Emergency Department Call**

Hospital respondents in nine of the twelve CTS communities cited difficulties with physicians' ED coverage as a significant issue, although not necessarily among the top three pressures they faced; it often arose just within the past two years.<sup>13</sup> In some sites, including Miami and Phoenix, communitywide ED coverage problems were noted for many, mostly surgical, specialties. A particular problem cited was the difficulty assuring ED coverage by physicians responsible for treating trauma, such as neurosurgeons, orthopedists, and plastic surgeons. In other communities in which ED coverage was a problem, the coverage shortages were spottier, limited to one or two specialties.

Numerous reasons were cited for specialist physicians' waning interest in taking ED call: the perceived higher risk of malpractice litigation, especially in Miami; lack of reimbursement for treating uninsured patients; opportunity costs in terms of time away from their practices; and late and unpredictable hours.<sup>14</sup> In general, physicians who now spend much less time in the hospital consider ED call to be a greater intrusion than when their professional days revolved around hospital care. Again, in those communities in which many specialists are employed by hospitals, ED coverage was not described as a major problem.

In the communities experiencing significant ED coverage problems, most hospitals reluctantly have started paying physicians for taking ED call or have guaranteed payment for services rendered for those patients lacking health insurance, or both. Typically, hospitals were paying physicians about \$1,000 per day for ED coverage in specific important specialties, such as neurosurgery. One hospital reported paying neurosurgeons \$10,000 per week for ED coverage and 120 percent of Medicare payment rates for uninsured trauma patients.

But hospitals expressed concern not only about the current cost of assuring ad-

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equate ED coverage, which remains relatively small, but also about the potential future costs associated with the precedent of paying physicians for time spent on ED call. Hospitals in Miami and Syracuse reported that physicians in specialties or at system hospitals where ED coverage is not a problem have become aware that other physicians are being compensated for taking call and therefore are beginning to demand on-call payment as well. Thus far, hospitals have mostly been successful at resisting the spread of on-call compensation.

### **Hospitalist Programs**

Relying on the findings from CTS interviews from 2002–2003, Hoangmai Pham and colleagues documented the rapid increase in the use of hospitalists across CTS markets.<sup>15</sup> Growth among hospitalists is continuing. In the words of an Orange County hospital executive, “The use of hospitalists is almost universal at this point. It really is the case of the tipping point phenomenon; we suddenly reached that point here, and just everyone uses hospitalists now.”

Although most respondents remain positive about the increased reliance on hospitalists, particularly to address issues of hospital use and costs, there have been consequences for hospital-physician relations. In the words of a Seattle group medical director, “[Because of hospitalists], we literally have docs that have not set foot in a hospital.... Consequently, they’re not going to CME [continuing medical education] programs there. We don’t have a whole lot of physicians that are on committees in the hospital.... It’s changed the whole practice of medicine.”

Hospitalists have decreased the presence of not only primary care physicians in the hospital but specialists as well. In the words of Phoenix physician group executive, “Because hospitals are hiring hospitalists, there’s not an ongoing, outpatient relationship between orthopods and the doctors at the hospitals.” This respondent blamed this phenomenon for a “disintegration” of relations between doctors and hospitals.

### **Competition As A Potential Source Of Cooperation**

As independent physicians have distanced themselves from or have even actively started competing with hospitals for patients, hospitals have reacted in a variety of ways, across the spectrum from overtly adversarial to more collaborative. Similarly, across CTS sites, physicians have had differing responses to the new environment.

The forms of collaboration that were common in the 1990s—for example, PHOs and medical staff organizations (MSOs)—have received little attention in recent years. Nevertheless, respondents in many sites, including Syracuse, Miami, Phoe-



nix, northern New Jersey, and Seattle, observed that PHOs had either dissolved or become inactive through this decade. In some communities, such as Boston, PHOs continue to be important organizations and have evolved from organizations primarily involved with accepting capitation risk to organizations focused on responding to cost and quality incentives coupled with fee-for-service, such as P4P. Indeed, this transition has led to P4P incentives applying to preferred provider organization (PPO) as well as health maintenance organization (HMO) enrollees.

However, in most CTS sites, hospital attention has turned to the challenge of the direct competition from physician-owned facilities. A few hospitals have attempted to challenge physician competition by invoking “economic credentialing,” whereby hospitals revoke the admitting privileges of physician investors in competing ventures.<sup>16</sup> A prominent example is in Little Rock, where in response to the physician-owned heart hospital and the recent opening of an orthopedic/spine hospital, the board of Baptist Health System formally adopted economic credentialing as part of its bylaws, arguing that physicians had an economic conflict of interest that could damage Baptist and therefore should not be allowed on staff. Affected physicians have sued, and the issue is now in the courts.<sup>17</sup>

Most hospitals, however, have not attempted economic credentialing, not wanting to alienate physicians, who remain a major source of admissions. Rather, they have attempted to respond to the changed relationships between physicians and hospitals through two main strategies: joint venturing and employment.

■ **Hospital-physician joint ventures.** In the former approach, aware that specialists would otherwise seek to raise capital from other sources to support new service lines, some hospitals have established joint ventures with physicians. Hospitals’ strategic rationale for joint ventures is straightforward: When threatened with losing most of a particular set of services to a competing freestanding entity, such as an ASC or an imaging center, hospitals often decide, in the words of one respondent, that “half a loaf is better than none.” Hospitals that enter into joint-venture arrangements with physicians expect hospitals to retain some of the revenues they otherwise might lose and also assume that the collaboration will help assure continued physician referral of patients who need inpatient hospital services.

A few hospital executives commented that entering into a joint venture with physicians leads to better quality and service and generally makes the particular service line more successful, ultimately producing a net revenue enhancement for the hospital. Most, however, acknowledged that they were being reactive, concluding that the joint venture was a way to reduce potential lost revenues from outmigration of services to physicians.

For physicians, hospitals might be viewed as desirable joint-venture partners because of their capital, their management experience, and the broader pool of patients that might be attracted. Some physicians thought that a physician-hospital joint venture was a way to avoid risky, head-on competition with the hospital.

In growing numbers of cases, the separate hospital and physician rationales for

joining together have proved decisive, as physician-hospital joint ventures were taking place in at least nine of the twelve CTS sites. However, in other cases, physicians have chosen to enter joint ventures with the increasing numbers of private firms, such as U.S. Oncology, that contribute capital and management expertise to a joint venture with a physician group.

Many joint ventures occur between nonprofit hospitals and for-profit physician entities and, accordingly, raise concerns regarding Internal Revenue Service (IRS) regulations on tax-exempt status. In general, hospital-physician partnerships must further the charitable purpose of the hospital, which must be able to demonstrate that it exercises sufficient control over the joint venture to ensure that community benefits are met, whether or not it owns the majority of the venture.<sup>18</sup>

The parties also have to be concerned about the federal antikickback statute, which prohibits any direct or indirect payment for referral of Medicaid or Medicare business. However, many kinds of ASC joint ventures fall into a safe harbor—a provision of the law that eliminates their liability for actions that would otherwise violate the antikickback provisions. Safe harbors do not apply to certain other physician-hospital joint ventures, such as cardiac catheterization labs.<sup>19</sup> To avoid potential legal problems in these situations, hospitals and physicians in CTS sites have also engaged in time-sharing arrangements whereby physicians lease hospital equipment, such as MRI imagers or a cardiac catheterization lab, at “fair market” return to the hospital, so that the physicians can capture the technical component of the fee that otherwise would go to the hospital.

The strategic and legal considerations that enter into hospitals’ attitudes toward joint ventures were summarized by a hospital executive:

The main motivation for pursuing joint ventures with physicians on outpatient facilities is that 50 percent is better than nothing. Doctors always want to do something; we get asked daily about different joint ventures. The critical thing is making sure that joint ventures are legal. [Our caution] makes our relationship with doctors more fractious.

Joint venturing with some physicians raises concerns about the impact on the broader medical staff. Physicians in less profitable specialties are increasingly resentful of what a Phoenix health plan respondent described as “catering” to the profit-generating physicians, especially cardiac and orthopedic surgeons. Furthermore, a Little Rock respondent suggested that it is “risky for the hospital if they alienate some groups by having an arrangement with another.”

Indeed, some hospital systems have established firm policies of not participating in joint ventures with physicians because of either the legal concerns or a strategic determination that they would be able to keep most of the service volume in the face of direct physician competition. At the same time, hospitals that do not enter joint ventures often respond to the potential competitive threat by attempting to provide a more hospitable environment for physicians—for example, improving operating room scheduling—to take away one of the reasons that physi-

*“Emphasizing service lines that feature particular specialists could threaten relationships with physicians who are not included.”*

.....

icians initiate new ventures in the first place.<sup>20</sup>

Some hospitals that have failed to preempt physician-owned facilities have decided to aggressively compete with them by deeply discounting their own services to try to prevent the physician-owned entity from getting a foothold in the market. One hospital developed this aggressive competitive stance because it thought it was “indispensable” to health plan networks and therefore could make up for aggressive discounting of these competitive services by increasing rates on other services over which it had near-monopoly control.

■ **Hospital employment of physicians.** In some communities, such as Boston, Cleveland, and Seattle, AHCs and multispecialty group practices have long employed physicians. In these communities, physicians’ entrepreneurial activity has been much less than in the other sites. Now the forces that have threatened physician-hospital relations have led some hospitals back to employing physicians again; however, this time the focus has been on specialists.<sup>21</sup> Hiring specialists serves a number of purposes. Although some hospitals attempt to promote service lines with participation from an open medical staff, others have decided that a service-line strategy often requires a close working relationship with particular physician expertise as an integral part of the service line.

Hospitals that have recently moved to a physician employment model attempt to integrate physicians into management of the service line to have greater control over how services are provided and marketed.<sup>22</sup> In addition, the employment model permits hospitals to associate with particularly prominent physicians who have a market following, which might be enhanced when marketed as part of the hospital’s service line.

By its very nature, this form of service-line product requires greater hospital collaboration with the physicians involved. In a number of cases, hospitals essentially participated in a bidding war to obtain the services of highly skilled specialists to serve as an integral and prominent part of the service-line branding and marketing strategy.

At the same time, emphasizing service lines that feature particular specialists could threaten relationships with the larger number of community physicians who are not included. Sometimes hospitals attempt to brand a service line with participation of all qualified specialists on the medical staff. However, increasingly, the hospital’s service-line brand does not include the participation of some of the medical staff. More rarely, hospitals might seek to move from a fully open medical staff to a closed one in which only selected physicians can use certain hospital facilities.

The decision of Swedish Medical Center in Seattle to hire prominent neurosur-

geons and orthopedic surgeons produced a major political problem for the CEO, who barely survived a no-confidence vote by the medical staff. Many of the staff were concerned that although the hospital was nominally maintaining an open staff, it would siphon off many cases from the voluntary admitting staff, who might be relegated to second-class status. In this case, the physicians thought that the hospital had taken the initiative to go into competition with its own medical staff physicians.

Some hospitals have found the need to selectively hire specialists to meet their obligations to staff the ED as an alternative to paying physicians generous per diems for taking ED call. Others, notably in Miami, Cleveland, and Greenville, used employment to help specialists on the staff cope with a challenging malpractice coverage environment and keep them admitting to the hospital. In Miami, where the high cost of professional liability insurance has caused many physicians to drop coverage altogether, hospitals have resisted making numerous employment commitments; the Baptist Hospital System has provided malpractice indemnification for physicians willing to provide ED coverage as an alternative approach to addressing the problem of coverage by physicians.

### **Policy Implications And Conclusions**

Important national and local initiatives to improve patient safety and quality assume a general alignment of interest between medical staffs and hospitals. Improved patient safety envisions shared use of new health IT; hospital P4P to improve quality requires active participation by admitting physicians; and hospitals and physicians could collaborate for improved chronic care management for the frail elderly and patients with severe chronic conditions.

Similarly, a major source of wasted spending lies in unwarranted intensity of hospital and physician services, particularly for patients in their last months of life.<sup>23</sup> Yet instead of working together to address excessive health care spending, physicians and hospitals have renewed a “medical arms race” that is driving up costs even faster, sometimes as collaborators but increasingly as competitors.

The health care system has relied on hospitals to serve as providers of last resort for uninsured patients with emergencies. Hospitals in turn have relied on community physicians to be on call to their EDs. But that reliance is now called into question as even more insured and uninsured patients seek care in EDs that have problems assuring physician coverage.

Policymakers need to examine the degree to which various existing policies are inadvertently contributing to the deterioration of physician-hospital relationships. Some policies are providing a stimulus to undesirable competition; others preclude areas of potential cooperation.

The pattern of hospitals and physicians competing with each other to expand provision of selected specialty services, such as imaging and certain tests and procedures, reflects distortions in reimbursement structures for the facility compo-

ment of services. If payments were set so that the profitability across various services was more uniform—the intent of reimbursement policies—incentives for hospitals and physicians to invade each other’s “turf” would be reduced. The CMS has begun to address this issue for Medicare with a rule to revise payment for inpatient services.<sup>24</sup>

Some, including the Medicare Payment Advisory Commission (MedPAC), see long-standing restrictions on gain sharing between hospitals and physicians as hindering hospitals’ ability to work constructively with physicians.<sup>25</sup> For example, hospitals are precluded from offering financial incentives to physicians to work to reduce hospital costs, such as agreement on selecting an agreed-upon set of implants used in orthopedic surgery. Indeed, the ability to reduce costs through such cooperative purchasing is one factor in the attraction of specialty hospitals to physician-owners.

Restrictions on kickbacks to physicians prevent hospitals from subsidizing staff physicians’ use of IT in their offices and are thought to have slowed developments likely to improve quality and reduce costs; this is being addressed by Congress. Finally, broad exemptions from physician self-referral restrictions—for example, for services performed personally by the referring physician, for services performed in specialty hospitals, and for surgical services performed in ASCs—have fueled physicians’ investments in these areas and, in the view of health plan respondents and others, have led to physician-induced demand of services.<sup>26</sup>

These are difficult policy issues, with trade-offs among cost, quality, access, and patient convenience. In approaching these issues, policymakers should consider the policy’s effect on physicians’ and hospitals’ ability to work together. A still-practicing physician CEO of a hospital summarized the problem this way:

If the health care system is going to evolve, then [physicians and hospitals are] going to have to figure out how to work together to look at efficiency and information sharing. I think we have a few tools in place here to facilitate that discussion, but I am not sure what the drivers are going to be.

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#### NOTES

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- no. 2 (1996): 195–206. The twelve communities studied in depth as part of the CTS are Boston; Cleveland; Greenville, SC; Indianapolis; Lansing; Little Rock; Miami; northern New Jersey; Orange County, CA; Phoenix; Seattle; and Syracuse.
6. In Round Three, responses on hospital pressures were obtained from forty-seven hospital executives, including thirty-seven CEOs; in Round Five, responses were obtained from twenty-eight hospital executives, including twenty-two CEOs.
  7. Berenson et al., “Specialty-Service Lines.”
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