Hospitals Employing Physicians: Still a Sound Strategy If Done Right

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Key Board Takeaways

Board members should challenge hospital and medical staff leaders to develop an exceptional professional home for employed physicians and advanced practice providers. Tactics to promote greater retention and engagement of employed practitioners include:

- Revising compensation methodologies with less emphasis on productivity incentives
- Organizing employed physicians into a multidisciplinary group practice structure
- Investing in physician leadership on the front lines of clinical care
- Reducing practitioner burnout by making systemic, structural changes in clinical care activities

Most hospitals today are struggling to maintain the workforce vital to their operations. When it comes to the physician workforce, there are several approaches hospitals can take to meet their needs. Through most of the 20th century, hospitals simply affiliated with doctors in private practice by appointing them to their medical staff organizations. In the 1980s and early 1990s, as managed care companies became significant players in the healthcare marketplace, hospitals flirted with the direct employment of physicians. This was mostly employment of primary doctors who could funnel "covered lives" to their employer in a competitive marketplace. Often this new hospital–physician dynamic played out poorly and by the late 1990s hospitals in many parts of the country were divesting themselves of these new employees.

As the 21st century got underway, hospital employment of physicians once again became common. This reversal was largely driven by physicians who were struggling in private practice and sought out hospital support. Private practice was left behind either because the challenges of keeping a small business afloat had become too stressful, there was an inability to recruit and hire new colleagues, or the practice had become financially untenable. Furthermore, many younger physicians found that private practice did not match their lifestyle preferences and desire for a better work-life balance. Through the first and second decades of this century hospital employment of physicians has grown steadily.

Employment of physicians is a costly addition to hospital budgets. Nevertheless, hospitals have multiple motivations that justify the expense:

- To retain essential current members of the medical staff who might otherwise leave the community
- To enhance recruitment efforts to fill needed vacancies in the hospital's medical staff development plan
- To bolster essential or high-reimbursement service lines and ensure adequate call-coverage in critical specialties
- To expand market share by establishing new practices and locating them strategically
- To prevent an erosion of market share by competitor health systems willing to aggressively recruit and employ physicians
- To prevent third parties from becoming dominant employers of physicians who then contract them back to the hospital at unfavorable terms
- To command the market power to raise fees

In 2000, nearly 60 percent of physicians were in independent practice, but that number has dramatically declined. The percentage of U.S. physicians employed by hospitals, health systems, or other corporate entities grew from 62 percent in January 2019 to nearly 74 percent as of January 2022.[1] The high prevalence of practitioner burnout, further exacerbated by the pandemic, has been a significant driver of this ongoing shift to employment.

Today, in a diminishing swath of the country, competition to employ doctors is between a hospital and local private practice options. More significant has become competition between hospitals and various third-party players. According to Avalere Health, from 2019 to 2021, hospitals and health systems saw a 9 percent growth in physician practice acquisitions, while corporate entities (e.g., insurers and private equity firms) saw an 86 percent growth.[2] Hospitals and corporate entities now own 53.6 percent of physician practices—hospitals own 26.4 percent and other corporate entities own 27.2 percent. Currently, the single-biggest employer of physicians in the nation is the Optum division of the UnitedHealth Group.

Creating a Rewarding Workplace for Physicians

While most hospitals now employ significant numbers of physicians and advanced practice providers, most are doing too little to hold on to these valued practitioners. Turnover rates are high, approaching 50 percent at seven years of employment. In general, physician engagement scores don't seem to improve or correlate well with increased hospital employment. Handing out roses on Doctors' Day is simply not going to cut it if the goal is to have a stable, high-functioning physician workforce.

Board members should ask hospital and medical staff leaders what they have been doing to create an attractive professional home for medical practitioners. Such a home would provide physicians a reasonable degree of autonomy and a sense of control over their clinical lives, create an appealing work-life balance, build a spirit of professional collegiality, and provide intellectual stimulation often lost to physicians once they leave their academic training institutions. Such a professional home would facilitate greater practitioner–patient interaction with fewer administrative burdens and less demand for numbing throughput.

What efforts should board members be looking for to distinguish their institution from others that hire doctors? A reasonable starting point is to reassess how employed physicians are paid. The current prevailing model is based on productivity and places physicians on a treadmill of days packed with short, unfulfilling patient visits. The assumption

1 Avalere Health, "COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021," Physicians Advocacy Institute, April 2022.

2 For an overview of the corrosive effect of private equity's entrance into healthcare, see Laura Katz Olson, *Ethically Challenged: Private Equity Storms U.S. Health Care,* Baltimore, MD: Johns Hopkins University Press, 2022.

underlying this model is that physicians will only work productively when given financial incentives to do so. The actual result is often burned-out practitioners, dissatisfied patients, diminished quality of care, more disruptive practitioner conduct, and staff turnover. To design a more rewarding compensation model, involve employed practitioners in the process. Rather than addressing productivity lapses through financial punishment, hospitals should invest in physician leaders who can manage the problem collegially to achieve appropriate expectations.

This raises another important tactic to strengthen hospital–physician relations. Hospitals must adequately invest in physician leadership. While it is important to provide relevant education to new medical staff leaders and to a hospital's physician executives, attention should also be paid to developing physician leaders on the front lines of clinical practice. This is where most employed doctors spend their time and where they need a colleague who can promptly address their daily concerns as well as provide coaching and guidance.

Hospitals with a significant number of employed practitioners should consider organizing them as a semi-autonomous multidisciplinary group practice. If designed properly and well-executed, this model provides doctors with an appropriate degree of autonomy over their professional lives. It combines some of the strengths of the private practice model with the resources and benefits provided by an integrated delivery system. Large group practices have a track record of delivering higher quality care and greater professional stimulation.

Any hospital interested in strengthening its bond with its employed doctors must address the epidemic of physician burnout. Three in five physicians reported at least one manifestation of burnout in the winter of 2021–2022. (In a similar timeframe, one study also found satisfaction with work-life integration dropped from 46 percent in 2020 to 30 percent in 2021 and average depression scores rose from 50 to 52 percent.)[3] Too many hospitals have tackled this problem by focusing only on efforts to strengthen practitioner resilience and mindfulness. But evidence suggests that health systems that want to make a more meaningful dent in these statistics need to make structural, systemic changes to the way they conduct business.[4]

Hospitals don't need to cede the employment of physicians to insurers, private equity firms, or health system competitors. Any hospital can create a rewarding professional home for its physicians and advanced practice providers. For motivation, just look at the success many hospitals have had with nurse retention when they create and invest in "magnet programs." It is always hard to move away from the status quo, but it happens when concerned board members step up and challenge their institutions to do better.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

3 Tait Shanafelt, et al., "Changes in Burnout and Satisfaction with Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic," *Mayo Clinic Proceedings,* Vol. 97, Issue 3, March 2022.

4 While there are many resources that provide suggestions, a particularly useful one is *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*, Washington, D.C.: National Academies Press, 2019.