21st-Century Health Care — The Case for Integrated Delivery Systems

Francis J. Crosson, M.D.

It was 1933. The United States was in the midst of a severe economic downturn that was to become the Great Depression. Data from 1929 showed that U.S. health care expenditures had reached 4% of the U.S. gross domestic product, a sum that was believed to threaten the country's financial recovery. After nearly a year of work, the Committee on the Costs of Medical Care, chaired by Dr. Ray Lyman Wilbur, the president of Stanford University, published its findings and recommendations.[1] The first boldface recommendation read, "Medical service should be more largely furnished by groups of physicians and related practitioners, so organized as to maintain high standards of care and to retain the personal relations between patients and physicians."

The committee had reached this recommendation after reviewing evidence that the group-practice environment tended to produce higher-quality and more efficient care than disaggregated forms of practice. Nonetheless — with notable exceptions, such as the Mayo Clinic, the Geisinger Health System, Kaiser Permanente (where I work), and other isolated instances of integrated delivery systems based on group practices — the transition the committee called for has not taken place. I believe it needs to happen this time around.

The United States must make health care coverage available to all citizens. The recent experiment in Massachusetts has shown that near-universal coverage can be attained but that waste resulting from unnecessary and unsafe care must be eliminated if the system is to be financially sustainable. The primary cause of unnecessary care is the costly brew of expensive technology and fee-for-service payment of physicians.[2] Most physicians want to do the right thing for their patients. It is easiest for them to do so when their decisions about what services to provide are guided, as much as possible, by science and patients' needs rather than by personal financial considerations. This goal can be accomplished reasonably well through prospective payment of a physician group that, in turn, pays its physicians appropriate salaries. The Massachusetts Special Commission on the Health Care Payment System recently announced its intention of moving away from fee-for-service payment in favor of prospective payment, believing that this change could significantly slow the growth of health care spending.

But there is a problem. Prospective payment for physicians' services has been shown to work well at the medical-group or health-system level but not at the individual-physician or small-practice level. In fact, experiments with individual capitation by health plans in the 1990s turned out to be financially unmanageable for physicians and created concerns that for some the degree of potential personal financial gain or loss made the approach ethically challenging.

Successfully replacing fee-for-service physician payment with forms of prospective payment will require changes in the organization of physician practices and in the structural relationships between physicians and hospitals. Physicians will have to work together across specialties, work in tandem with hospitals, and be able to respond collectively to new payment methods. These changes have not materialized more broadly to date because of a classic chicken-and-egg conundrum. Payers have little incentive to develop innovative prospective payment methods unless there are enough delivery systems capable of receiving and succeeding with these payments. Conversely, physicians and hospitals have little incentive to do the hard work of integration when the payment system provides little reason to do so.

Thus, two interacting sets of changes need to occur: movement away from fee-for-service payment of physicians toward prospective payment, and multispecialty integration of physicians combined with hospitals to form new "accountable" systems of care. The case for such change was well presented last year by the Commonwealth Fund Commission on a High Performance Health System.[3] There are two non–mutually-exclusive ways in which the changes envisioned by the commission could take place: rapid transition for established integrated delivery systems and gradual transition for the majority of physicians and hospitals. There are already 100 or more integrated delivery systems in the United States — they are especially

common in the West and upper Midwest — that are able to accept prospective payment and that could make care more efficient as a consequence. Other health care communities, on the other hand, are still quite disaggregated. In such places, the transition from fee-for-service and solo or small-group practices to prospective payment and integrated delivery systems will need to proceed in a more stepwise fashion. This process can begin with early forms of payment reform, which will in turn drive greater structural integration, which can increase the capacity for additional payment reform, and so on. The ultimate degree of integration will depend on local market realities — not every accountable system of care must be cut from the same structural mold. Similarly, assumption of all risk on the part of delivery systems is not a necessary component of a successful model. Kaiser Permanente's history shows that risk sharing between the payer and the care delivery system can work quite well.

The development of more integrated, accountable care systems should bring other benefits in addition to the opportunity to reduce costs. A number of studies have shown that integrated care is positively correlated with improved quality, which is achieved through the coordination of care among specialties, the effective use of information technology–based decision-support tools, and other key aspects of integrated systems. Such integrated health care entities are increasingly attractive to newly minted physicians, particularly primary care physicians, who perceive them as offering a supportive environment and recognize the ability of group practices to moderate, at least to some degree, the growing income disparity between primary care physicians and specialists. The growth of integrated care systems may thus be at least a partial correction to the growing tendency of U.S. medical students to shun primary care as a career.

How long would it take to achieve a stepwise transition from complete disaggregation to accountable care systems? Some observers believe that it will be impossible to attain this goal at least until the older generation of physicians retires. Others, who recall some constructive responses from physicians and hospitals to the apparent inevitability of managed care in the early 1990s, believe that the shift could proceed much more quickly — especially because many physicians are more dissatisfied with the status quo than they were 15 years ago. In addition, many hospitals, observing the disintegration of the traditional hospital-staff model of physician self-governance, are seeking new ways of "clinically integrating" with physicians. Finally, the advances in clinical information technology that have occurred in the past decade provide a practical integration tool that was largely absent previously.

What would need to happen to launch the process? Public and private payers would have to initiate the cascade of changes by offering new payment opportunities to delivery organizations that are willing and able to accept them. I, among others, have called for the Centers for Medicare and Medicaid Services, the country's largest payer, to build on the Medicare Physician Group Practice Demonstration by developing new models that will allow the agency to share financial risk with delivery systems.[4,5] Models that prove successful could be adopted by private payers as well. Regulators would need to remove certain barriers to integration while ensuring that system development does not lead to abusive pricing. As in Massachusetts, government leaders could seal the deal by establishing a stable long-term vision for delivery-system reform that could be counted on by physicians and hospitals seeking to lead the necessary changes. Most important, though, is that we begin this process of incremental change as soon as possible.

Dr. Crosson reports serving as chairman of the Council of Accountable Physician Practices. No other potential conflict of interest relevant to this article was reported.

All opinions expressed in this article are those of the author and do not necessarily represent the views of the Medicare Payment Advisory Commission (MedPAC), on which the author currently serves as vice-chairman.

From the Kaiser Permanente Institute for Health Policy, Oakland, CA.

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