

**The Accountabilities of
Physicians and Health Care Organizations
in the Era of
Health Care Reform**

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Abstract

The state of Japanese health is ranked the first in the world; however, in the past decade there have been intense discussions about health care reform in Japan. One of the characteristics of Japanese health care organizations (HCOs) is that physician chief executive officers, who do not receive official managerial training, should administer their facilities. So far, the administrative sections in Japanese HCOs have not significantly developed in comparison with those of U.S. HCOs.

In the United States, on the other hand, it is well known that highly developed administration sections managed by nonphysician executives and clinical sections are separated; nevertheless, under the circumstances of “managed care”, the relationships between physicians and HCO administrators are changing rapidly.

This report discusses about the competencies of HCO administration by comparing the situations of Japanese and U.S. healthcare administration and organization.

First, comparative studies of health care systems revealed that the highly centralized Japanese system did not require the development of Japanese HCO administration, whereas the U.S. decentralized and market-oriented systems compel U.S. HCO administrations to have functions similar to those of the Japanese government. The salient differences between Japanese and U.S. HCO administration are; pricing negotiation, contract renewal, the number of plans and payers, and development of micro level health care delivery systems.

Second, the history of three types of transformations, those among physicians, hospitals, and physician-HCO relationships, can make it easy to understand the development of U.S. HCO administration. In the 1990s, most hospitals, physician practices, and even insurance companies were integrating structurally, but they have reached an impasse. Now they are struggling to integrate functionally and clinically. In this context, physician executives play

a crucial role in HCO administration. Under these turbulent conditions, consumer judgment finally determines the shape of health care systems. For consumers to make accurate judgments, the transparency and accountability of health care givers become essential.

Finally, in the U.S. the number of physician executives has been growing rapidly in the last two decades. In order to administer their organizations, these executives must acquire the requisite management skills. In the near future, the implementation of education systems for physician CEOs of Japanese HCOs will be imperative and methodologies for these systems must be developed.

Introduction

The World Health Organization (WHO) announced in the report “WHO 2000” that the state of Japanese health is ranked the first in the world, and the performance of the Japanese health care system is tenth in the world. Does it mean that the Japanese health care system is not so functionally elaborated compared with the state of Japanese health, or it is still working very well to promote health? At least, the Japanese people believe that there is much room for reforming the health care system, and in the 1990s, Japanese administrators of health care organizations (HCOs) have continued to struggle with the health care reform.

Two major “distinguishing” characteristics of Japanese health care organizations, when compared with those of other Western countries, stand out. One is “the absence of a clear functional separation” among HCOs, and the other is that “Japanese law regulated that all chief executive officers of HCOs be physicians”, although these physician executives do not receive formal education or training in administration for HCO (Graig, 1999). So far, the administrative competencies of Japanese HCOs have not been questioned and the administrative sections in HCO have not developed in comparison with those of HCOs in other industrialized countries. Last year this regulation was amended, and a non-physician administrator can now be a CEO of a Japanese HCO. The reason for this amendment is not because administrative competency is important, but rather, because the trend is toward “deregulation” in Japanese industry.

In the United States, on the other hand, it is well known that the administrative sections of HCOs are far more developed and HCOs are divided into separate clinical and administrative sections. However, under the circumstances of “managed care”, the relationships between physicians and administrators of HCOs are changing rapidly. In this report, the following topics are discussed using the situations in the United States for comparison. We also seek to identify the role of the administration of HCOs for the coming health care system.

1. Why could the function of HCO administration not be developed in Japan?
2. In the future, will it be necessary for this field to develop?
3. If this proves necessary, then what kind of knowledge will be required for the future Japanese HCO administrators?

Section 1: Why could the function of HCOs' administration not be developed in Japan?

Comparative study of health care systems

Modern health care systems are roughly composed of two parts: financing and health care delivery. HCOs are major components of the health care delivery system of each country. Therefore the administration of HCOs is strongly affected by the nature of the respective national health care systems. First, through the comparative study of health care systems, we will try to find the answers to the first question.

Objectives of comparative study

Recently, researchers of many nations have turned their attentions to comparative studies of health care systems, not only in industrialized countries but also in developing ones. One of the reasons is that despite the existence of many kinds of health care systems, their principal objective is common: to improve people's health. The push for health care reform has created a tendency for systems to converge toward common ground. Wessen (1999) noted that modern health care systems share many similarities in heritage and confront similar problems and ideological and policy concerns, and as Evans (1986) insisted, "the point is that by examining other people's experience you can extend your range of perceptions of what is possible."

Classifications of health care systems

In this report, the Japanese and American health care systems are classified according to the following models of OECD (1997) classification.

- 1) The ***national health service model***, which is used in the U.K., is characterized by universal coverage, general national tax financing, and national ownership and/or control of the factors of production
- 2) The ***social insurance model***, which is used by Germany and Japan, has compulsory universal coverage within a framework of social security and is financed by employer and

individual contributions through not-for-profit insurance funds and public and/or private ownership of the factors of production.

3) The U.S. *private insurance model* is characterized by employer-based or individually purchased insurance, individual and/or employer financing, and private ownership of the factors of production.

In order to make clear the differences in the structures of each nation's health care system, two major characteristics of national policies and eleven structural "parameters" are identified. (Table 1).

Degree of market orientation and context of decision making

According to Anderson (1989), each national health care system is located on the "continuum" from the "market-minimized" pole to the other "market-maximized" pole. By this "health services continuum" theory, the U.K. is placed on the "market-minimized" pole, while the U.S. system is placed on the "market-maximized" pole and the Japanese system may be placed near the point of "market-minimized" pole. The position of a system in the continuum is determined by the political centralization of decision-making. The other major characteristic is how decision-making is done, "cooperation" or "competition". In many European countries and in Japan, decisions tend to be "rationalized and harmonized by negotiations between aggregated functional interest groups". By contrast, in the United States, most decisions are made by the result of the competition among "a plurality of competing interest groups".

Using these parameters, we will try to compare the differences of the framework of Japanese and U.S. health care systems.

Characteristics of Japanese health care system

The Japanese health care system is, as mentioned above, the social insurance system which covers essentially every Japanese citizen and helps to keep him or her healthy--number one

in the world--with almost the half the cost of that of the U.S. The other characteristic of this system is the equity of provision of medical care, all patients are free to choose any HCOs in a “free access” system and their benefits are essentially the same for all plans due to a uniform fee schedule for reimbursement. From the health care provider point of view, in spite of the existence of about 5,000 health plans, benefits and also fee schedules are set by law and are uniform, so the Japanese system is considered “single plan” and “single payer”.

Yoshikawa (1996) cited that “in essence, the Japanese health care financing system is a global budget system with a very tight bureaucratic pricing control.” “Manipulation of the fee schedule serves as one of the primary mechanisms by which government regulates the supply of medical services, utilization rates, and aggregate health care expenditures. Lower health care expenditures have not been realized accidentally; systemic manipulation of the fee schedule has been a cost containment tool.”

Characteristics of United States health care system

The U.S. health care system is characterized by such terms as “complex”, “uncoordinated”, “loosely structured”, “fragmented”, and “nondesignated.” It is quite difficult for the Japanese to understand the system because of its intricacies and wide disparities. Furthermore, since the system is changing quite rapidly, especially in the last decade, information about the U.S. health care system soon becomes out-of-date. Certain characteristics of the American system nevertheless remain constant:

Three Characteristics of American Health Policy (Kovner, 1999).

1) The strong antitrust policy

The United States has long been concerned about the dangers of monopoly power and has pursued a strong antitrust policy. The typical response of American health policy is to advocate proposals that fragment powerful groups that presumably compete with one another.

2) Lack of strong negotiators

Following directly from the first characteristic of the American policy response is the absence in the United States of institutional structures negotiating between major groups of health care providers and the government and/or NHI board of directors.

3) Decentralization and persistent social experimentation

In contrast to Western European and Canadian strategies of comprehensive health care reform and strong centralized regulation, American strategies are characterized by far greater decentralization and by more persistent social experimentation.

Differences in structure of health care systems between Japan and United States (Table 2)

First, the Japanese system is characterized by strong centralization. The government determines nearly all aspects of healthcare regulation at not only the macro, but also the micro level, including pricing and financing, covered procedures, and the structure of healthcare delivery systems. The Japanese government also plays a managing role in the process of negotiation, an essential component of the Japanese system. Three major players - - the government, healthcare providers, and insurers - - are represented in the process. Providers' interests are secured by the Japanese Medical Association (JMA), which enjoys a great deal of authority throughout the process of negotiation. While this process is often characterized by acrimony and deadlock, once the parties arrive at compromises, the government implements such policies, ensuring strict compliance from providers and insurers. Ikegami (1999) named this approach to negotiation a "muddling through" system. After guidelines are established, all players collaborate within the framework under the watchful eye of the relevant governmental administration. We may conceive of the Japanese system as a giant top (Fig. 1). At the tip are the healthcare givers, those who serve patients directly. The next level is that of the healthcare organizations, directing the activities of physicians, nurses, and other caregivers; municipal, prefectural and national governments and JMA of each respecting level represent successively higher levels of this hierarchy, enforcing policies established through the aforementioned negotiation process. The HCOs and providers must function within this large "top", as few HCOs can survive

outside of the Japanese universal insurance system. By controlling the pursestrings, the national government maintains ultimate control over the process at the zenith of this top.

On the other hand, the U.S. system shares little of the hierarchical centralization intrinsic to that of Japan. In place of a single, all-encompassing “top”, numerous tops of different sizes, shapes, and colors represent the U.S. healthcare framework. Individual providers, insurers, and HCOs combine to form their own “tops” within contractual frameworks; while the state and federal governments regulate certain aspects of these relationships, governments necessarily remain outside of each top. Since every top in the American system is self-contained, each must duplicate all the functions of the centralized Japanese system. There is thus a remarkable degree of autonomy and diversity within the U.S. healthcare system, especially at the HCO and insurer levels.

Furthermore, there are no strong national negotiators to represent the various players in the American system. Competition rather than collaboration is the hallmark of American healthcare. The question is who is the consumer for whom. The stakeholders of HCOs and of insurance companies are not always the same. The main stakeholders of HCOs are patients, but insurance companies’ stakeholders are their subscribers, most of whom are healthy people.

Differences in administrative functions between Japanese and United States HCOs

The differences in function between Japanese and American HCOs may be classified in four areas: pricing negotiation, contract renewal, number of plans and payers, and the development of micro healthcare delivery systems. These distinctions stem directly from the nature and philosophy of each nation’s healthcare system.

1. Pricing negotiation

In the U.S., healthcare is priced through market mechanisms, creating a wide disparity that results from differences in geography, perceived quality of care, level of competition, and

insurer contracts. Determining costs is a crucial function of the market, one which is unnecessary in Japan because the government sets prices fixed by a complex process of negotiation. The large number of insurers, combined with the virtual lack of regulatory supervision, engenders a complex pricing structure in the U.S.

The increasing trend toward managed care organizations and consolidation in the insurance industry have forced healthcare providers to consolidate into larger entities that enjoy economies of scale and can better negotiate with insurers.

As a price maker, the Japanese government is quite strong compared with U.S. managed care organizations (MCO). In case of MCOs, whether an MCO can become a price maker or a price taker depends on which negotiators are stronger between the MCO and the negotiating HCO.

2. Contract renewal

In Japan, once an HCO receives accreditation through the Japanese medical insurance system, the accreditation continues unless the HCO violates regulations. In the U.S., HCOs must contract with various insurers, often at differential rates, on a limited-term basis. U.S. HCOs must maintain extensive records of performance and clinical outcomes in order to meet insurers' standards and obtain better rates.

This contract renewal procedure also changed the U.S. HCOs' accountability. According to quality management, the productive functions of organizations are described as a figure (figure 2). When an HCO submits the outcome data for contract renewal, it must also disclose the procedures from "input" to "outcome". Furthermore if an HCO wants to improve outcome data for better contracts, it must monitor and improve the whole process, a task called quality management. It is one of the most crucial tasks for today's HCO administration. In Japan, supervisors of HCOs check only the "input", such as the reports that survey the size of medical staffs or facilities or whether HCOs abide by the government regulations. Since outcomes are not surveyed and the procedure for contract

renewal for Japanese HCOs is simpler, they do not pay much attention to quality management and, as a result, their accountability suffers.

3. The number of plans and payers

Since American HCOs have to contract with many different kinds of health plans on the basis of market mechanisms, they have to undertake huge numbers of transactions with each health plan. The costs of these transactions raise the proportions of administrative costs in the budgets of HCOs, this reducing profits and efficiency.

At the beginning of the month all Japanese HCOs make claims for all patients who received medical care in the last month and submit them to the payers. After two months the payers reimburse the HCOs in the amount. Although there is a system of utilization review, it is quite generous compared with that of U.S. insurers. Therefore almost all claims are paid in entirety; furthermore, there are no discounts or delays in payment. For the management of HCOs, this procedure is one of the most time-consuming tasks; however, it is still quite simple compared with that of U.S. HCOs, which must make many kinds of claims in accordance with various health plans and submit claims to each insurer. As the fee schedules are made uniform by the government, Japanese physicians usually do not care in which kind of health plan the patient before him takes part and give each patient the same treatment regardless of coverage.

4. Development of micro level health care delivery system

In Japan, new medical technology is implemented after the government integrates these developments into the plan structure.

For example, when opening a new intensive care unit (ICU), a hospital makes a plan according to the standard set by the government, which regulates the structure of the ICU room, the required number of medical personnel, and so on. Since Japanese HCOs must

abide by the regulations of the established healthcare delivery systems, they can never develop a new healthcare delivery system without governmental approval. Usually new healthcare delivery systems are imported from the foreign countries, especially from the United States.

Japanese physicians tend to think of the rendering of medical service as a matter between only physicians and patients. Japanese HCOs are usually considered the vehicles that give physicians the opportunities to render medical services. On the other hand, in the U.S., HCOs provide medical services within a self-designed framework. In this approach not only the physicians but all other relevant sections take part in and construct this system.

Summary

The differences between U.S. and Japanese health care systems can account for the main causes of the differences between the both countries' administrative functions of HCOs. In the Japanese highly centralized social health care system, HCOs' administrative functions had no strong incentives to develop, whereas under the market-oriented and decentralized health care systems, since a U.S. HCO must have similar functions as Japanese government play a role, its administrative functions are forced to develop. There are four salient differences in HCO administrative functions between two countries: Price negotiation, contract renewal, the number of payers and health plans, and the development of micro health care delivery systems.

Section 2: Transformations in physician-HCO relationships

The first section revealed the reason why Japanese HCO administrative functions did not develop as much as U.S. ones. The next issue is whether it will be necessary for a Japanese HCO administration to develop in the future. It is informative to review the states of U.S. HCOs and derive the requisite conditions for HCO administration to perform toward future. It is not easy to give a comprehensive description of it, however, for U.S. HCOs always transform and evolve.

To understand the U.S. HCO, one must focus on three points: transformation in physician practice from solo practice to corporate practice of medicine, transformation in HCOs from a single hospital to integrated systems, and transformation in physician-HCO relationships.

In order to investigate these transformations historically, it is better to separate the 1990s from earlier periods. The ongoing pace of change in this period is so rapid and extreme that one must especially pay attention to the interpretations of these alternations.

It is symbolic of this fact that Shortell, who is one of leading scholars for the field of HCO administration, had to reedit and revise most of his book, “Remaking Health Care in America” (1996) after only four years. He carried out extensive research about HCO “integration” and insisted on its importance in the first edition. Nevertheless, he cannot but comment on today’s situation by saying that “the overall value of integration has been questioned” in the second edition.

Transformation in physician practice

“Socialized medicine” and “the corporate practice of medicine”

Two aspects of traditional American physician ideologies have affected the U.S. health care systems for a long time: the distaste for “socialized medicine” and “the corporate practice of medicine” (Starr 1982). In the United States, the health care systems in which the government plays the major role, such as the national service model or social insurance

model, are labeled “socialized medicine” (Kaufman 2000). American physicians dislike “socialized medicine” and so far, American physicians have rejected governmental implementation of a universal social insurance system (Drake 1994).

Starr (1982) mentioned “the dislike of physicians for “socialized medicine” is well known, but their distaste for corporate capitalism in medical practice was equally strong.”

Traditionally, American physicians condemned physicians for entering the corporate practice of medicine. As they refused to be controlled by governments, they also have been kept from becoming both salaried and invaded by business corporations. The reason that physicians intended to remain independent is that they think it unethical to practice under the conditions that “impair the free and complete exercise of medical judgment”. (Rodwin 1933) However, as the number of physicians was increasing and the external environment of health care was changing rapidly, they began to enter the world of “corporate” practice of medicine.

Until the late o 1970s, physicians were completely independent from HCOs and practiced medicine solo. They connected to HCOs through the members of medical staff organizations (MSOs) in HCOs. In order to perceive the physician-HCO relationships in the U.S., it is important to understand the functions of a traditional MSO.

“Managing Health Services Organizations”, the textbook for the management of HCOs, describes the MSO as follows.

Medical Staff Organization (MSO)

An HCO’s organizational structure is different from that of other regular organizations. In regular organizations, there is only one authority that can manage the whole body of the organization and this governing body supervises this authority. There are two kinds of authorities in U.S. HCOs: “the formal authority of position” rests in the managerial hierarchy and “the authority of knowledge” is possessed by members of the MSO. The governing body supervises these two authorities, but if that body does not possess enough

power to manage these two parties, then three types of authorities exist in one organization. Such situations are called “a dual-pyramid form of organization” or “two lines of authority”. The problem is that in many cases physician members of the MSO cannot take part in the pyramid well and conflicts between two authorities often tend to occur. The two authorities are connected via the governance body and, if this overseeing authority cannot unite the two authorities these conflicts cannot be solved.

This style of two authorities violates the principles of the organizational structure (Rakich 1992).

In Japan the independence of clinical process and administration in U.S. HCOs is believed to be the virtue of American HCOs, while in U.S. this separation is regarded as a disadvantage or “peculiar bureaucracy”. (Starr 1982, Lieber 1999)

Solo practice

As we entered the 1990s physicians realized that it is quite difficult to remain solo practitioners because of the rapid changes in external environments. At first they resisted, but soon they began to consolidate and thus prepare for future changes: physicians combine into larger entities to achieve economies of scale, access to capital, leverage in negotiating managed care contracts, and diffusion of responsibilities for business management. It is interesting that these reasons are quite similar to those for which U.S. HCOs consolidated.

“The solo practitioner – an endangered species?”

According to AMA manual, it seems that “the day of the solo practitioner is quickly drawing to a close.” (AMA 1996) Recently the number of group physicians is increasing rapidly; as a result, the number of solo physicians is declining. At least new physicians will not enter solo practice in the future. (AMA 1999)

The corporate practice of medicine

“Integration Strategies for the Medical Practice is a response to current trends in health care. This book is written to help you, the physician, make positioning decisions for your practice. “

This is an excerpt from the preface of the manual that AMA published for physician practitioners in 1996. One aspect is that as hospitals have been evolving in the history of health care, dependencies on HCOs of physicians took place and started to grow (Davidson 1996). The other aspect is that, as the number of physicians was increasing, there emerged physicians who dared to enter the world of business entities. Anyway physicians are forced to enter the “corporate” world of health care in order to survive in this world.

At one time the AMA condemned the “corporate” practice of medicine strictly, but the AMA could not but allow it and had to lead members appropriately into this world. This manual declared: “As the “cottage industry” of physician practices moves into sizeable, complex business ventures, they are developing their own legacy.”

Shortell (1996) also notes that to survive in this new era of health care, physicians must commit to change. While building on the success of modern medicine, physicians need to master a whole new set of skills to thrive in this new health care environment. I call this confluence of past medical success and new realities the new practice of medicine.

Transformation in health care organizations

The 1990s - Integration and disintegration

The 1990s present serious difficulties for describing the transformations of the relationships among physicians, HCOs, and insurers. From the 1970s, consolidation among providers and HCOs proceeded at a furious pace as a wave of “merger mania” swept the American healthcare industry. In the past decade, however, many such amalgamations broke up or struggled to improve their performance. One could characterize the 1990s as a period of integration and disintegration for HCOs.

Integrated Delivery Systems (IDSs)

Shortell (1993) defines integrated or organized delivery systems as “a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.”

Kongsvedt (1997) divided IDSs into three categories: systems into which only physicians are integrated, those in which such providers combine with facilities (hospitals and ancillary sites), and those that amalgamate physicians, facilities, and insurers. While in theory such alignments are beneficial from the standpoint of economies of scale, cost-effective allocations of clinical resources, and strong negotiation positions, in practice these consolidated enterprises often face serious challenges in managing cumbersome bureaucracies and in satisfying the needs of clients.

Disintegration?

Until 1997, HCOs integrated and expanded at a record pace. When the expectations for improved performance were disappointed, though, HCOs began to disintegrate. Young (1999) argues that the wide disparities in the performance of consolidated healthcare organizations can be traced to the nature of the consolidation. “True integration”, in which organizations realize an organic unity, results in successful delivery and financial performance, while “pseudo integration”, in which the various elements function collectively only on paper, usually results in poor performance or outright failure.

At the early stages of “merger mania”, Herzlinger (1997) predicted that IDSs and HMOs would encounter fundamental difficulties. She noted that “IDSs have integrated structurally, [but] they have disintegrated culturally”, insisting that “only markets can cope with these diverse activities.”

Robinson (1999) posits the reasons for the failure of HCO consolidation from the point of view of consumers: providers have tended to consider only managed competition while neglecting the preferences of consumers, thus duplicating the mistakes of the other managed care organizations. Because their preferences are so varied, consumers find that having a diverse array of options is more important to them than is receiving discounted care.

The future of health care organizations

In the U.S., The ideal HCO structure does not yet exist, but marketplace mechanisms compel American HCOs to evolve continuously in order to survive. Shortell (2000a) described the new paradigm that is arising from the current one and to which HCOs must subsequently adhere. (Chart 2)

Mintzberg (2000) views the current fragmentation of hospitals into competing sections, with trustees, administrators, physicians, and nurses pursuing divergent agendas, as deleterious to effective decision making. Each functional section works only for its own interest and never cares about the organizational interest; strategic planning for an HCO thus suffers, as the involved sections cannot form a united vision for the entity. On the basis of his ten-year study of the role in physicians in hospital planning, Ashmos (2000) suggests involving physicians in the strategic decision-making process to engender more efficient and correct preparation for and adaptation to rapidly changing circumstances.

A sign of the difficulties experienced by HCOs is the wide discrepancy between the level of consumer satisfaction with hospital care and the outcomes of such care, indicating that greatly better treatment success rates do not always parallel with the patients' satisfaction. Grazier (2000) insists that hospitals must focus more attention on the process of treatment as a whole, rather than merely on outcomes. Such a comprehensive medical approach would provide a "continuum of care" offering consumers a more transparent and patient-friendly process and atmosphere. Hospitals must both monitor their administrative

frameworks and communications networks more effectively and coordinate care services more seamlessly if they are to satisfy the consumers who evaluate them.

It is thus clear that HCOs that are both functionally and clinically integrated are essential to offer clients this continuum of care. In this context, the roles of physician leadership become indispensable. Nevertheless, Shortell (2000b) points out that the velocity of these integrations is extremely slower than was expected and it may take the next decade to reach this goal.

Discussions concerning the characteristics of the “ideal” HCO are not limited to market-driven systems, however. The WHO’s 2000 report advised that health-policy authorities redesign the decision-making structures of HCOs so as to move from hierarchic to incentive-based systems of authority. The WHO report identified five factors that such systems must consider: Accountability, Autonomy, Market Exposure, Financial Responsibility, and Unfunded Mandates. In structuring HCOs, the WHO also recommends taking “virtual integration”, rather than traditional vertical integration, into account.

Cutler (1999) posits that the current trend, which began in the 1990s, is toward just this sort of incentive-based reform. In particular, incentives on the demand side have increased; HCOs are expanding their health plan offerings instead of increasing patient cost-sharing. The “introduction of market forces into the medical care system”, however, “conflicts with the ethics of medical care distribution.” HCOs of all countries seek to satisfy consumer preferences, to demonstrate excellent treatment outcomes, and to improve productivity, but these HCOs are also bothered by ethical conflicts. Under the emerging incentive-based paradigm, consumers will judge the extent to which an organization achieves these objectives; in response, each health providers including physicians and HCOs must maximize their degrees of accountability to be judged by consumers.

The paper “Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations” (1998), in which AMA renewed the role of physician leadership of the medical staff organization in a HCO, also emphasized that the accountability of physicians become crucial instead of physician autonomy.

Summary

It is useful to see the transformations of U.S. HCOs, including physicians and their practices, to understand the development of U.S. HCO administration. Transformations in U.S. HCOs are so rapid and aggressive that the process is difficult to describe, but it is crucial to focus on three types of transformations: those among physicians, hospitals, and physician-HCO relationships.

Traditional physicians were completely independent from any other entities. Between the physician-HCO relationships, U.S. physicians and hospitals are separated structurally and connected through the HCO medical staff organization, which caused the issue of dual authority. Once a physician practice was no longer a corporate entity, physicians were compelled to enter the corporate practices of medicine, for they cannot deal with such complicated and stressful environments. U.S. hospitals also could not run as a single hospital under the situations of managed competitions, they began to integrate furiously. In this process, physician practices also participated in this integration.

Structurally physicians, hospitals, and occasionally even insurance companies have integrated however, their current performances are stumped. Many of these integrated delivery systems cannot satisfy the consumers’ preferences and keep losing money. Not only structural but also functional and clinical integrations are required to resuscitate from these situations. In order to achieve this goal, the existence of physician-leadership is imperative.

The ongoing U.S. phenomenon might not be limited to market-oriented health care systems. As WHO recommends, incentive-based systems are next generation's health care systems. Under this system, consumers evaluate the value of HCOs including physicians and they own the rights to choose their health care.

Finally transparencies and accountability of health care givers become essential for consumer judgment in any kind of health care system.

Section 3: Physicians and HCOs administrations

In the trend of “true” integration of U.S. health care providers, previous section pointed out the physician leaderships are imperative for achieving this goal. Then, what kind of physicians must perform physician leaderships in the United States?

Whereas Japanese HCO administrators are primarily physicians who receive little or no official education or training for HCO administration, while U.S. administrators are mostly non-physicians with expertise in this field. In Japan, the regulation was amended last year to enable to be an HCO administrator. The question remains whether Japanese non-physician HCO will increase; in the United States, the number of physician executives, those who possess an M.D. and formal education in healthcare management and work in the field of HCO administration, are increasing rapidly (LeTourneau 1997). Will the number of physician administrators of United States HCOs continue to increase in the future?

The advent of U.S. physician executive

The number of physician executives in American HCOs has been increasing rapidly for the past twenty years. (graph 1)

There are several reasons for this growth in the representation of physicians in the field of HCO management.

1. The number of physicians has been growing, engendering tougher competition. In order for physicians to “cross over” into HCO administration, they must acquire the requisite managerial expertise. Moreover, physician executives face a unique dilemma: in dealing with fellow physicians, such administrators possess more clout when interacting as

physicians; in dealing with nonphysician management colleagues, however, physician executives gain more respect when interacting as managers.

2. Two major changes in the healthcare delivery environment have lured physicians into management: the mounting pressures of managed care and the increasing drive toward vertical and horizontal integration of delivery systems. These two trends require physician executives to play the central role in designing and implementing systems for administering both managed care organizations and integrated delivery systems.

In order to reach the highest levels of HCO management, a physician executive cannot rely solely on medical training, but must demonstrate the same managerial competency that nonphysician executives show. There is therefore the need for comprehensive managerial education for those physicians who move into HCO administration.

Shortell (2000b) insists that the current crop of physician executives, “the second generation”, are not trained enough to lead effectively and advocates a third generation of leadership as follows:

There is a need for a third generation of leadership in which all physicians in medical school and residency programs learn some basic managerial and leadership skills in communication, conflict management, change management, team building, and continuous improvement methodologies in order to be better prepared to practice in a changed environment and accept as well as contribute to new leadership approaches. A subgroup of these physicians will need to choose clinical careers that combine medicine and management in helping to restructure the delivery system.

Questionnaire survey to Japanese Physician Executives

In addition, I surveyed Japanese HCO physician administrators to determine whether they perceived the need for managerial education for HCO executives. From this questionnaire

survey, Japanese HCO physician administrators also have great interests in the managerial/administrative education systems for HCOs. Most of them demand the necessity of education systems and research for HCO administration.

It seems that time has come for Japan to implement the education systems for HCO administration and U.S. education systems must be didactic for future Japanese systems.

Summary

In both countries with different health care systems, existence of physician leaderships is imperative for functionally and clinically integrated HCOs administrations. In order to perform accurate and effective physician leaderships, physician executives must acquire the requisite management skills.

The next critical issue is the methods of this educational system. In the U.S., there are many kind of education systems; if Japan implements a certain kind of education system for HCO administration, U.S. systems are very helpful references; however, at the same time it is also crucial what kinds of U.S. systems the Japanese systems will use as models because U.S. education systems for HCO administration range from a profit-maximum system to an ethics- and public health- based system.

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Section 1

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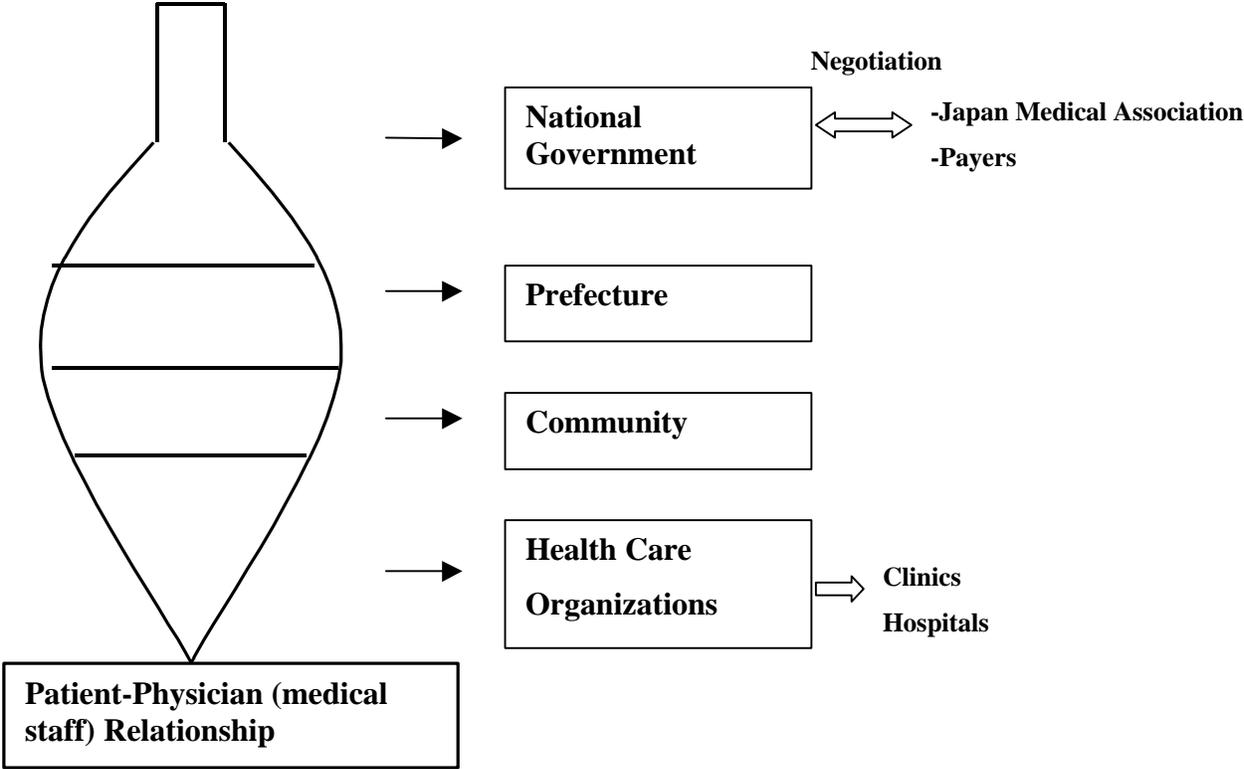
Table 1

Salient differences in the structure of Health Care Systems

- Degree of market orientation
- Context of decision-making: corporatist versus pluralistic interest competition
- Structural characteristics of health care systems
- Degree of “medical dominance”
- Role of payers
- Role of insurers: “third-party agents”
- Role of government
- Degree of centralization
- Degree of specialization: The balance between primary, secondary, and tertiary care
- Extent of pluralism in the system
- Sources of financing
- Methods of financing health care
- Modes of payment to providers
- Rigor of cost control methods

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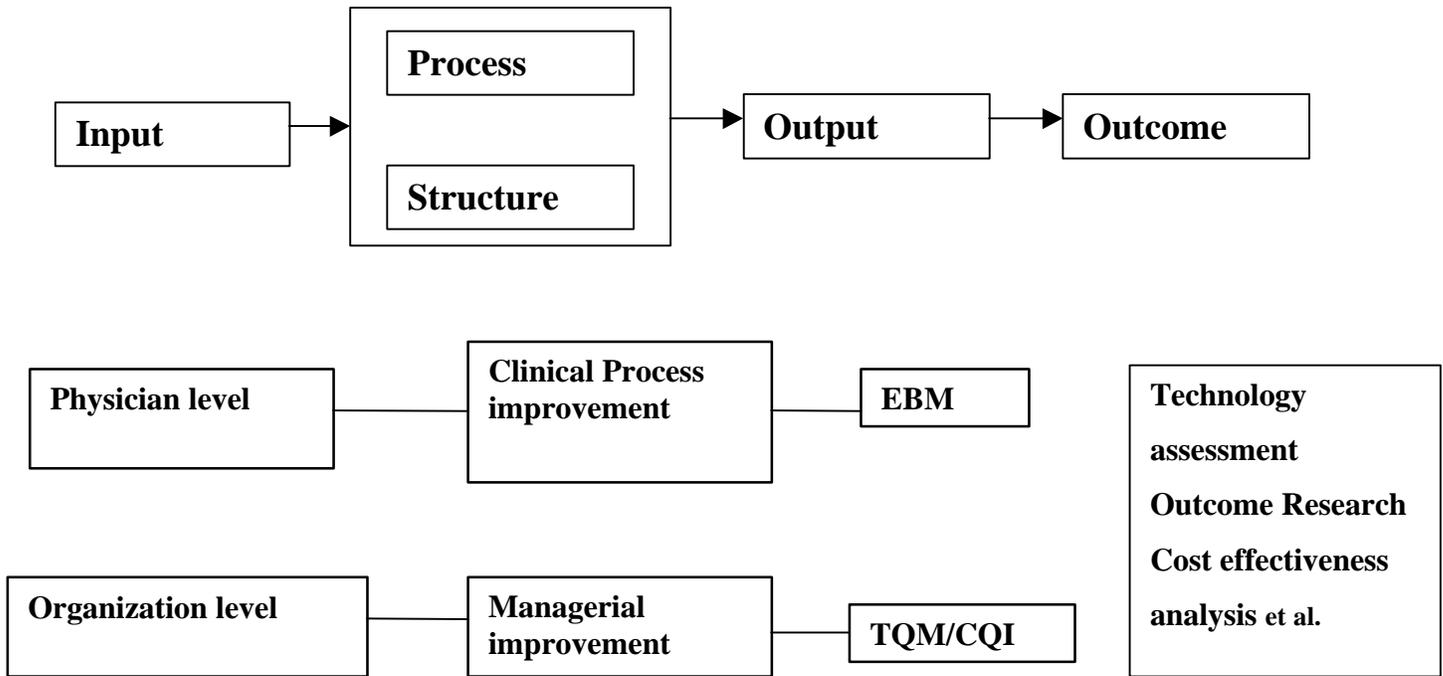
The “Giant Top” of Japanese Health Care System (Fig 1)



Differences between the Japanese and U.S. Health Care Systems (Table 2)

	Japan	U.S.
1 Insurance system		
Medical insurance system	Social insurance system	Private insurance system plus partial social insurance system
Payment system	“Single” payer system	Multi-payer system
Reimbursement system	Fee for service By mandatory fee schedule	Multi-reimbursement system
2 Health policy		
Strong anti-trust policy	No	Yes
Collaboration vs. competition	Collaboration	Competition
Existence of strong negotiators	Yes	No
Degree of centralization	Highly centralized	Highly decentralized
Physician practice		
Medicine	Socialized medicine	Market-oriented medicine
Medical practice ↓	Corporate practice of medicine “Clinics”	Independent practice of medicine Corporate practice of medicine
HCOs		
Pricing function	No	Yes
Negotiation of contract	No	Yes
Contract renewal	“No”	Annual negotiation
Complexities of Payment system	Simple “Single-payer system”	Complicated Multi-payer system
The number of health plans	Functionally “single plan”	Multi health plans
The development of Micro delivery systems	No	Yes

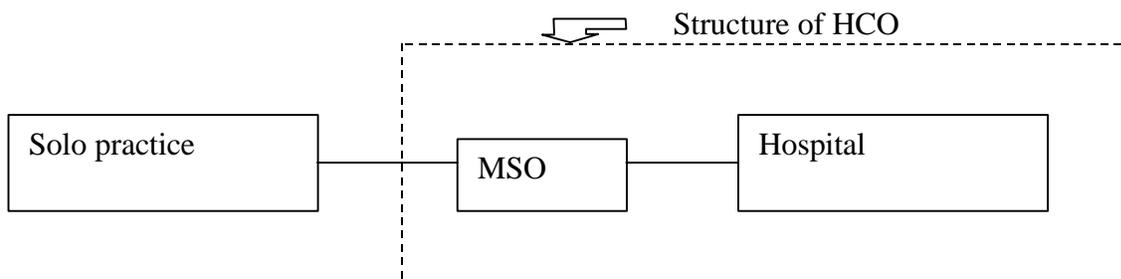
Production Process in Quality Management (Fig. 2)



Transformation in Physician – Health Care Organizations Relationships (Chart 1)

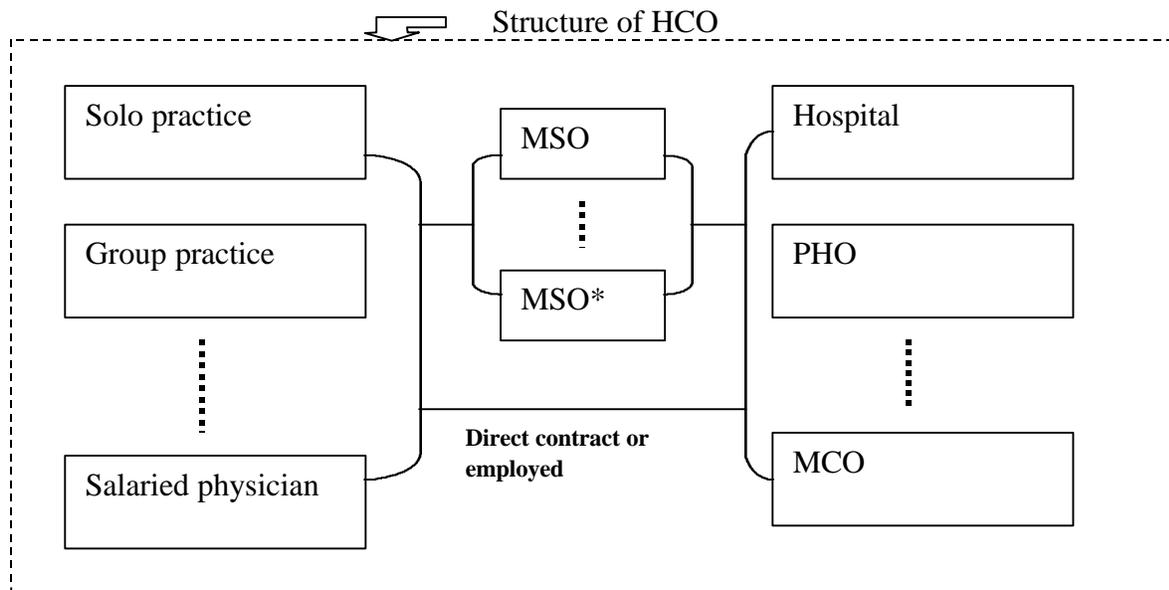
Traditional Model:

In the organizational scheme, physicians were not part of the corporate medical structure. The term “health care organizations”(HCOs) described those entities that provided health care, regardless of whether these institutions were for-profit or not. While physicians interfaced with HCOs, usually through contacts with an HCO’s “medical staff organizations”(MSOs), the physicians remained outside the structure of the HCO.



Corporate Model:

In the past thirty years, largely due to increased competition among providers, many organizational schema for physician practice have arisen. Individual physicians are now components of all-inclusive HCOs, whether they practice individually or in groups. These HCOs have a complicated series of relationships with various insurers and regulating authorities, negotiating markedly different contracts under markedly different terms, depending on size and market power.



MSO = medical staff organization, MSO* = management service organization,

PHO = physician hospital organization, MCO = managed care organization

Future Model?

Recently, consumer dissatisfaction with the burgeoning bureaucracies has led many HCOs to seek new, more responsive organizational structures. Greater access to physicians, more choices for providers and hospitals, and more transparent regulations concerning covered services and procedures are elements of this “third way”. As with prior alterations in the way healthcare is provided, this set of changes is also a response to increasing competition and represents the effects of market mechanism.

Old and New Paradigm for Health Care Organizations (Chart 2)

1.1.2 Old Paradigm

- Emphasis on acute inpatient care
- Emphasis on treating illness
- Responsible for individual patients
- Emphasis on tangible physical assets
- All providers are essentially similar
- Success achieved by increasing market share of inpatient admissions
- Goal is to fill beds
- Hospitals, physicians, and health plans are separate
- Managers run an organization

1.1.1 New Paradigm

- Emphasis on the continuum of care
- Emphasis on maintaining and promoting wellness
- Accountable for the health of defined populations
- Emphasis on intangible knowledge/relationship-based assets
- Differentiation based on ability to add value
- Success achieved by increasing the number of covered lives and keeping people well
- Goal is to provide care at the most appropriate level
- Virtual and/or vertically integrated delivery system
- Managers oversee a market
- Managers operate services

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Questionnaire survey to Japanese Physician Executives

Objectives:

1) Japan Medical Association (JMA):

Young forum members; Young executives of JMA, two members per district for seven districts in Japan (14 members)

2) All Japan Hospital Association (AJHA):

All board members (59 members)

Survey period; 2000 April-May

Respondents:

JMA 13/14 (92.9%)

AJHA 24/59 (40.1%)

Results of survey:

The types of HCOs

Japanese clinics (without beds)	6
Japanese clinics (with bed)	1
Hospitals	29

The number of the hospital beds

<100	16
100= <200	7
200= <300	3
300= <	3

The age of HCO administrators

< 30	0	0.0%
30 - 39	2	5.6%
40 - 49	9	25.0%
50 - 59	6	16.7%
60 - 69	7	19.4%
70 - 79	10	27.8%
> 80	1	2.8%

The number of years spent in current administration position

< 1	0	0.0%
1-5	2	5.6%
6-9	2	25.0%
10-19	18	16.7%
20 - 29	7	19.4%
30 - 39	5	27.8%
>40	2	2.8%

The percent of time devoted to administrative duties versus clinical duties

<10	6	16.7%
11 - 19	4	11.1%
20 - 29	3	8.3%
30 - 39	5	13.9%
40 - 49	6	16.7%
50 - 59	1	2.8%
60 - 69	2	5.6%
70 - 79	2	5.6%
80 - 89	1	2.8%
> 90	6	16.7%

The present critical issues for health care administrators

	1	2	3	4	5
Cost/Finance	20	15	0	1	0
Leadership skills	30	4	0	1	0
Professional staff interactions	21	12	2	0	1
Health care delivery concepts	27	8	0	0	1
Marketing	13	13	9	1	0
Ethics	28	4	3	0	1
Quality management	23	12	0	0	1
Risk management	26	6	3	0	1
Information technology	12	18	5	1	0
Revision of fee schedule	11	18	5	1	0
Amendment of "iryō-ho"	13	17	6	0	0
Health care reform	14	15	7	0	0

Needs for education systems for management of health care (organizations)

Yes	30	(83.3 %)
No	5	(13.8 %)
No response	1	(2.8 %)

Needs for research/study for management of health care (organizations) (32/36 – 88.9%)

Yes	32	(88.9 %)
No	2	(5.6 %)
No response	2	(5.6 %)

1999 survey of ACPE

Executive experience (years)

- Total number of years spent in management/administration average 9
- Total number of management/administrative positions held average 3
- Number of years spent in current management/administrative position Average 4
- Number of years working for current employer average 9

Time devoted duties

Administrative	70%
Clinical	30%

Growth in Membership of the American Physician Executive (Graph 1)

