

## PHYSICIAN UNIONS -- BARRIERS -- ALTERNATIVES

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Around the state, union organizers have been recruiting physicians. The more candid of these organizers will admit when questioned that physicians, even if they became members, would not be able to bargain collectively with managed care plans, HMOs or insurance carriers. One must, then, immediately question the value of paying nearly \$700 to \$1,000 per physician each year in union dues when a union cannot bargain on their behalf.

Union organizers usually counter by saying that for \$700 - \$1,000 per year in union dues, physicians will have an opportunity to call upon the power of the national affiliate of the union or some other organized labor group to further their interests on Capitol Hill, and obtain for them a credit card bearing the union logo. Yet, this makes no sense. If each physician paid \$1,000 each to their state or county medical society Political Action Committee, they would have as much political clout as any union and they would not have to be worried that their lobbyists might have divided loyalties. Need anyone be reminded that the interests of organized labor have often been inconsistent with those of physicians. Indeed, is organized labor willing and prepared to demonstrate its solidarity with physicians and the medical community at large by dropping managed care options from their own union welfare plans? Will the unions strike against employers which insist on managed care options for their employees. The answers should be obvious. Managed care has skyrocketed in popularity because organized labor has embraced it as a means of lowering their cost of their own health care benefit plans. If this does not cause one to doubt the loyalty of unions to the cause of physicians, then consider the manner in which unions administer their benefit plans. As almost any physician who has worked for a union benefits plan will attest, these plans have frequently been the least responsive, most frustrating and slowest of payors.

But, even outside the health care arena, unions have not seen fit to side with physicians. For example, in the area of tort reform, unions have steadfastly fought every effort to eliminate patient and lawyer abuses or place reasonable limits on damages. To believe that a relatively small group of physicians within a union of three million or more laborers is going to have a substantial impact upon their legislative agenda or mindset, is simply folly.

It is not that organizing is a bad thing. It is not. It is just that a union is not a suitable or useful vehicle for doing so in most cases. If union membership is not the answer, then what is? There are other alternatives; but, again these alternatives require physicians to work together. And, that is no easy task. To date, their failure to do so has been the single greatest barrier to physicians playing a larger role in the shaping of the health care marketplace.

For a number of years physicians have blithely entered into PPOs, IPAs, and PHOs with, ordinarily, with little return on their investment. PPOs and IPAs have often been used by managed care companies, allowing them to quickly enter a new market and add new physicians to their panels with a minimum of cost. Since the PPOs and IPAs cannot negotiate fees for individual members, price has had to be "negotiated" on a take-it-or-leave-it basis, with the carrier or company, always free to strike a side deal with any physician willing to undercut his or her colleagues.

PHOs, now more frequently referred to as "Independent Delivery Systems" or IDSs, have, almost universally failed to serve the interests of physicians. Without exception these organizations end up controlled by the hospital's administration, regardless of the intended organizational structure and the promised sharing of power. Another variation on this same theme is the hospital-run Management Service Organization ("MSO") which are seeking to lure physicians with promises of reducing their burden of administration, management and marketing. These organizations have little likelihood of success for the same reason that PHOs have failed. Physicians cannot engage in collective bargaining and their ostensible partner, the hospital, is also their major competitor.

Is all lost? Perhaps not -- but physicians must organize and work together for their common good. A relatively new opportunity is now available. Physicians can join together (usually along specialty lines) to access the capital necessary to grow their practices, incorporate laboratories, ambulatory care centers, surgical centers, and other facilities within their practices, and attract world class management and install information systems to permit quality management, effective marketing, and contract negotiations. With the proper structure, physicians will, then, be able to legally bargain collectively

with managed care companies and other payors!

For this to work, physicians in the same or similar specialties must bring their practices together into a single, regional professional corporation. This does not mean that the physicians lose their existing practices or the individual character of their offices. The physicians' existing practices continue, as individual care centers, within the larger context of an umbrella professional corporation. Physician revenues continue to be based on individual practice revenues. Essentially, on a day-to-day basis, the operation of a physicians' practice does not change.

Once the professional corporation forms, it creates its own physician practice management company ("PPM"). The physicians control all of the stock of the professional corporation and a large majority of the stock of the PPM. The remaining PPM stock is used to attract high quality management and, ultimately capital. Since the project can be structured initially as a bankable transaction, no venture capital is required, thus maximizing physician ownership in the PPM. Moreover, due to the availability of stock, the physicians need take no money out of their own pockets to form these ventures. Rather, as part of the package, it is not unusual for physicians to receive stock and cash equal to as much as their previous year's actual collections.

By entering into a relationship with one another of this sort, physicians can retake control of the practice of medicine and also incorporate into their practices services which are now being provided by hospitals or other non-physician entities. The profits from these ancillary services can enure to the benefit of the physicians and, as importantly, allow physicians to maintain their control over the quality and availability of these services.

While non-physician owned PPMs have existed on Wall Street for some time, most have been controlled by insurance executives, real estate developers or worse. Nonetheless, they have attracted approximately 7% of the nation's physicians and, given the huge amount of capital available to them -- literally billions of dollars -- many more physicians will find themselves working for these non-physician owned PPMs in the near future. Physicians need only look to the independent drug stores to understand this natural progression. Soon the vast majority of formerly independent medical practices may operate under brand names just as the once independent drug stores now operate as part of national chain. Given this obvious evolution, physicians must either form their own PPMs or yield to the real estate developers and insurance executives.