The Changing Marketplace and its Impact on Physician Employment and Practices

By Thomas A. Lerner

Twenty years ago, health care practitioners witnessed a trend towards practice consolidation with medical management companies and institutional health care. The idea was to create a feeder system from primary care practitioners to specialists and hospitals. Productivity in that setting was increasingly gauged by the brevity of patient visits, the size of patient panels and volume.

Perhaps not surprisingly, the years since have seen a growth in physician dissatisfaction with the way that their practices have evolved. Few doctors chose to become physicians because they relished the prospect of interacting with health insurers, and none saw themselves as Charlie Chaplin's character in Modern Times, albeit with a stethoscope instead of a wrench. This dissatisfaction by the practitioner was met by every other participant in the system—patients, employers, insurers and government, all of whom believed that the cost of medical care was too great, and accessing that care was too complicated, all the while taking the quality of that care for granted.

With that context, the one common theme that emerged is that change was needed, even if there may be widespread disagreement about the means or methods of accomplishing that change. Our community is currently undergoing a transition in health care delivery. The extent to which that transition is occurring in anticipation of the Affordable Care Act ("ACA"), or independently of it, can be debated.

Swimming Against the Trend

In seeking to reduce costs and improve outcomes, Group Health Cooperative developed a model which they describe as the "Medical Home," as a means of providing more integrated health care services at a reduced cost. Significantly, one of the key steps that it took in this process was to substantially reduce the size of patient panels, along with incorporating a variety of other means of timely patient communication.

As a result of its efforts, Group Health reported an increase in physician and patient satisfaction, and reduced emergency department visits and hospitalizations. Because of improved communication with patients, the cost of reduction in physician panels was apparently offset through savings in other areas of this integrated health care system. To begin a cost-savings approach with a reduction in panel size must have required somewhat of a leap of faith, but the results have led to Group Health's approach being cited as a model during the health care reform debate.

Consolidation and Competition

As more fully discussed in the Center for Studying Health System Change in its December 2010 Community Report regarding the Seattle metropolitan marketplace, there has been an increase in competition among institutional health care providers. This is reflected in the increasing deployment of free standing emergency departments, as well as in the association of separate facilities into larger networks (e.g., Stevens Hospital in Edmonds is now part of the Swedish system; Northwest Hospital is now affiliated with the University of Washington). The free standing emergency departments serve the function that the roll-up of primary care practices did twenty years ago—they have become feeders to the hospital and its associated physicians. By establishing these facilities in locations separate from the hospitals, the free standing emergency departments provide deeper market penetration and patient feeder opportunities than emergency departments that are located at the hospital.

The growth of the institutional networks makes it increasingly difficult for the independent physician or small groups of physicians to operate profitably outside of that structure. Combined with the uncertainty of the economic impact of the ACA on reimbursement rates (but with a reasonable assumption that they will not go up), an increasing number of physicians are seeking the sinecure of hospital employment, rather than fee for service based income. This trend may have been foretold by the development of the "hospitalist" practitioner, although there are good reasons besides income stability to choose to practice in that setting.

The rise in emergency department visits (and thus, free standing EDs) is not simply a function of Americans becoming more careless or reckless, or materially in worse health resulting in an increased need for urgent care. Rather, it at least reflects an increased demand for ambulatory care, with the bulk of the increased ED usage by insured individuals.

A primary care physician with a desire to grow his or her practice could likely accomplish a great deal by scheduling office hours in the evening or weekends, even at the sacrifice of some 8–5 scheduling. In Congressional testimony offered on May 11, 2011, Center for Studying Health System Change Senior Fellow Dr. Peter Cunningham observed that studies from 2008 indicated that 29 percent of ED visits were for patients with semi-urgent or non-urgent needs, and that ED usage was influenced by the time of day and day of week when care was needed.

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Certain inferences about the future are invited. With the rise of the insured population as a result of the ACA, individuals who have been economically deterred from accessing the health care system are likely to seek more regular care. There will be a significant increase in demand for primary care physicians. Providing primary care services may become more economically viable in currently underserved areas, because the patient population will be insured rather than uninsured and unable to pay.

Competition and consolidation will lead to an increasing trend towards employment of physicians at least through the current period of economic uncertainty. There will continue to be a trend towards vertical integration of delivery of health care services, with an emphasis on gateway practices (e.g., free standing Emergency Departments; maternity care services). The Group Health model—which has support from within the ACA—if emulated by other institutional health care providers, may lead to stabilization of an employed physician model, with increased practitioner and patient satisfaction.

This thesis also suggests that primary care physicians should fare well economically, as they will be inundated with new, insured patients. Further, based on the Group Health experience, the attention of primary care physicians should lead to more selective need for specialized health care services and facilities. Inevitably, however, there will be a gap before our health care financial system adjusts to the new realities that will come with the increasing volume of insured patients, and new physicians can be confident that they will find financial stability through a primary care practice. ■

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