

Making Sense of the Trend Toward Hospital Employment

More hospitals are courting physicians, and more physicians are accepting their offers, but why?

This issue of *Family Practice Management* includes several items related to the topic of physician employment, from the personal issues to consider before leaving independent practice (page 9) to the key elements of an effective employment agreement (page 29). Why so much talk about employed practice? The trend is clear. More and more physicians, including primary care physicians, are becoming employed, particularly by hospitals. From 2000 to 2010, hospital employment of physicians has increased 32 percent. Roughly 20 percent of physicians today are employed by hospitals, and 40 percent are employed by hospitals and health systems combined. In 2012, only 39 percent of

ACOs have discretion on how they reduce costs. In the zero sum game of health care cost containment, what one player views as revenue, the other player views as a cost. As a physician, which organization do you think will be more likely to try to maximize your income while reducing the hospital's take – a hospital-based ACO or one run by physicians, especially those of the primary care flavor?

But what if ACOs aren't successful? What if they turn out to be a losing proposition because the continued skyrocketing cost of drugs, technology, and buffet-style, all-you-can-eat patient expectations for their care defeat ACOs' attempts to put a lid on things? Then, I believe we would have a redux of the late 1990s and early 2000s when, after a physician buying spree, hospitals decided that "owning physicians" was a losing proposition, and they dumped us. Except this time it will be harder for physicians to start up again on their own because of all the regulations, complexity, and costs. (Full disclosure: I was part of one of those

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physicians had an ownership stake in their practices, down from 57 percent in 2000.¹⁻³

Why are so many physicians flocking to hospitals, and why are so many hospitals welcoming them with open arms? For physicians, increasing costs, regulations, and the complexity of managing a practice are undoubtedly driving many to give up trying to do it themselves. The capital costs of private practice are now greater. Electronic health records, e-prescribing, patient portals, value-based reimbursement, and stricter HIPAA rules create new demands not present even five years ago. For hospitals, accountable care organizations (ACOs) and value-based purchasing pose a threat to the bottom line, so they need to become horizontally integrated to control the outpatient sector that feeds them and could starve them if properly incentivized.

Logically, hospital-based ACOs are more likely than physician-based ACOs to look aggressively to the outpatient sector for cost reduction instead of looking in their own backyard. Of course to succeed, hospital-based ACOs will try to reduce readmissions, emergency room visits, and perhaps even initial admissions but probably not with the enthusiasm of physician-dominated ACOs.

physician groups courted and then dumped by a hospital in the late 1990s.)

What is the alternative for physicians not wanting to go it alone? Well, if the local hospital is your *only* viable option, by all means go for it. But if you have an option to join an existing physician-led practice, I encourage you to consider it first. If no such beast exists in your community, consider banding together with other practices to create a larger, more sophisticated physician-run organization. It may seem the riskier option, but in the long run, I suspect it will be the safer and more lucrative one. **FPM**



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2. *Clinical Transformation: New Business Models for a New Era in Healthcare*. New York: Accenture; Sept. 27, 2012.
3. Shorett P. *The Revolution in Primary Care: Positioning Health Systems for the Future*. Boston: The Chartis Group; September 2012.