Richard W. Snyder II, MD
President's Page
Independence and Autonomy

If you like to contemplate the possibilities presented by large numbers, as I do, then US healthcare spending is right up your alley. The numbers speak for themselves: Total 2010 US healthcare spending: $2.6 trillion ($8,402 per person); percent of GDP, 17.9 percent. Broken down, the numbers invoke a "shock and awe" reaction: Medicare, $525 billion (20 percent); Medicaid, $401 billion (15 percent); private business, $534 billion (21 percent); households, $725 billion (28 percent – lowest ever). Private health insurance accounts for $849 billion. Of the total US bill, 45 percent is covered by federal, state and local governments. Based on the current trajectory, healthcare spending as a percentage of GDP could reach 25 percent to 30 percent!

These staggering numbers paint a picture that is intimidating and dire. It is hard to envision how the economy and our healthcare system can absorb the growth provided by Obamacare and the volumes of baby boomers as they mature into Medicare eligibility and their peak healthcare-need years. We physicians know that the healthcare system has much inefficiency and waste, at multiple levels, and that our limited resources can be allocated more wisely. But the real question is, who is best positioned to remove this waste and inefficiency from the system?

The economic drama of fee-for-service and private healthcare has three principal protagonists: insurance companies, physicians and hospitals. Each side of this triangle competes for healthcare dollars in a zero sum game dynamic. Historically, these three mostly have operated independently and frequently at odds with each other. When considering total healthcare spending, physician reimbursement accounts for an average of only 10 percent to 15 percent. But most importantly, virtually every dollar spent in health care ($2.6 trillion), either directly or indirectly, flows through a physician's pen (or more commonly, a physician's electronic orders). Physicians – not the hospitals or the insurance companies – make the decisions of when and how to spend the vast majority of the healthcare dollar, and the hospitals and insurance companies know this.

Previously, during times of healthcare economic and regulatory adversity consolidation occurred predominately within the hospital, payer and physician sectors to create economies of scale and leverage size to better compete with the other two. The 1990s saw a brief time of consolidation between hospitals and physician providers, mainly through an employment model. But this relationship was ineffective economically and, for the most part, was abandoned. Independent physician practice reemerged as the norm.

However, health economic and regulatory adversity has stormed back with a vengeance. Growing overregulation and relentless reductions in reimbursement, especially physician reimbursement, are beginning to have disruptive effects. Additionally, as the demand for health care increases and the financial resources to meet that demand progressively are limited, the governmental is pressuring all players to limit the cost and the waste. A consensus is emerging that greater coordination of care through alignment of provider services and capitation of services through ACOs and other models will meet this need. This consensus was manifested in the recent Obamacare laws facilitating ACOs and the Independent Payment Advisory Board. These factors are creating economic and market conditions threatening the viability and the independence of hospitals, physicians and payors. With shrinking dollars and growing regulation, the force will grow more irresistible toward consolidation and alignment not only within, but among, the hospital, physician and insurance sectors. This is disproportionately true for the physician group. Where once these three players operated independently, and in a rough though unbalanced equilibrium, they are beginning to align, resulting in interesting relationships, dynamics and sometimes unintended consequences.

A new reality is taking shape by which the merger of any two of these three entities in a local market can disrupt that equilibrium and facilitate the disruptive domination of the third. The leverage created by these alignments can alter the economic realities of supply/demand unfavorably and increase the cost of accessing health care. Because virtually every dollar decision of care must come from a physician, it is physicians who have a target on their backs and are attractive from an alignment perspective. If this group can be managed (i.e., controlled), so can the flow of healthcare dollars. Partly for this reason, physician practices are being acquired in a medical version of the movie "MoneyBall." Instead of acquiring players and paying them for their productivity measured in hits, runs and strikeouts, doctors are being purchased and compensated based on their productivity in RVUs, stents, surgeries, and admissions.

For the last several years, we have seen accelerating alignment between physician practices and hospitals, primarily in the form of an employment model. The targeted disproportionate reduction in physician reimbursement and overregulation has made independent physician practice increasingly untenable. Ostensibly hospitals have been motivated to acquire physician practices to lower costs through greater coordination of care and to meet the expected need for emerging bundled capitation payment models. But when hospitals and physicians are aligned in this manner, unintended (and cynically intended) consequences can result. This alignment can alter the economic dynamics, creating dominating leverage vis-à-vis the third player in that triangle: in this instance, the payor (insurance company). The unintended consequence can be one of higher cost to the local market and society. The aligned hospital-physician system can take advantage of the up to 3x greater technical reimbursement disparity for outpatient imaging services between the Medicare B and Medicare A (HOPPS) payment schedules. The aligned provider entities can leverage this relationship for greater reimbursement. Interestingly, new relationships are emerging by which insurance companies are attempting to buy physician practices to gain leverage with the hospitals and as a defensive maneuver. Other models are materializing in which a hospital and insurance company align. Finally, there is the mother of all alignments, the one by which all three come together – insurance company, hospital and physicians – all in one package. You can imagine the possibilities, both good and bad, and the unintended consequences of this type of amalgamation.

We physicians must never lose sight that our ultimate alignment is with the patient. I know this sounds quaint and perhaps idealistic, but this is at the core of why the vast majority of physicians went into medicine. It also is an idealism that our patients and the public desperately hope to be true. The patients inherently hope and believe that their physicians hold their relationship as ultimate, and that his physicians are acting in the patients' best interest. The real question is whether this physician alignment with other healthcare entities weakens the primacy of the physician-patient relationship. Does it affect the physician decision-making process in regard to the utilization of healthcare resources?

At the core of this most important of all alignments – that between doctor and patient – is the concept of physician independence and autonomy. The glue that creates the physician-patient bond is the trust derived from the physician's independence and autonomy. These are mutually sustaining. Society bestows us with independence and autonomy because we are trusted as the ultimate protectors and advocates of the patient's best interests. When the elements of independence and autonomy are transferred, the trust of the patient also can be. When trust is gone, so is the effectiveness of the physician-patient relationship and the healthcare process. Physicians must have the independence and autonomy to act in the best interest of our patients, and our patients must believe that to be true. Clearly our profession has examples of members who have abused that trust, independence and autonomy for personal gain, but these are rare. No one called for the abolition of the stock market and of the hedge fund system because of that one glaring example of abuse, and so no one should use examples of physician transgressions of trust as the premise to seize our ability to care for our patients without outside interference. Physician autonomy and independence must remain inviolate. I

idealistically believe that the vast majority of physicians place the patients' best interest above their own.

Perhaps the greatest threat to our independence and autonomy comes from within when we unknowingly and naively cede these rights, such as when physician practices merge with a hospital or insurance system. Done correctly, this alignment can be effective in coordinating care, lowering cost, increasing access, and improving quality. There are many different models and permutations by which these relationships can manifest. We as physicians are best positioned to serve as advocates for our patients in our pursuit of quality and cost effectiveness as owners and partners in the healthcare delivery system. The most prevalent alignment, however, is the employment model. Not all physician employee-employer models are the same. Most are not of the "master-slave" type of dynamic, and most can be positive if structured and done correctly. It is incumbent on the physician and physician groups that enter into these contracted alignments that the key elements of physician autonomy and independence are preserved in regard to patient care decisions. We must be ever vigilant that our independence and autonomy are not diluted, transgressed or transferred. We physicians are the ones who are best positioned to limit waste, correct inefficiencies, and, ultimately, lower costs in our healthcare system, but this is only by virtue of our independence and autonomy. Our independence and autonomy are as critical to us as physicians as are our stethoscopes, scalpels and prescription pads. Without them, we cannot function.

Independence and autonomy are our ultimate bond with our patient, and our ultimate weapon to fight disease. They always have been and always will.