

ulus to use a less-effective regimen and would lead to unnecessary strokes and disability. The Cardiovascular and Renal Drugs Advisory Committee considered these issues at length⁵ and slightly favored approval of only the higher strength.

A closely related issue in comparing a new anticoagulant with warfarin is the success of the warfarin group in maintaining an INR within the therapeutic range. In RE-LY, results were analyzed according to the amount of time during which patients' INR was in the therapeutic range. The greatest advantage of the 150-mg dose of dabigatran over warfarin was seen in the subgroup with less than the median time in the therapeutic range. Noninferiority of the lower dose was less strong-

ly shown when it was compared with well-managed warfarin dosing (which, of course, is not always achieved).

Ultimately, the FDA's decision to approve only the 150-mg strength was based on our inability to identify any subgroup in which use of the lower dose would not represent a substantial disadvantage.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Hospitals' Race to Employ Physicians — The Logic behind a Money-Losing Proposition

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U.S. hospitals have begun responding to the implementation of health care reform by accelerating their hiring of physicians. More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations (ACOs) and the prospect of more risk-based payment approaches. Whether physicians, hospitals, or payers end up leading ACOs will depend on local market factors, competitive behaviors, and first-mover advantage, but employment decisions made by physicians today will have long-term repercussions for the practice and management of medicine.¹

In the 1990s, hospitals acquired many physician practices of which they subsequently divested themselves. After the current cycle of physician-practice acquisitions, it will be harder to revert to private practice if relationships sour, since new payment structures and care models will make it increasingly difficult for traditional private practices to remain profitable. Many clinicians are unaware that hospitals lose money on their employed physicians, though hiring them may be a wise long-term investment. Understanding the economics of these decisions will help physicians to anticipate the evolution of their employment situations and see why hospitals

are making increasingly aggressive plans to acquire physician practices.

Hospitals lose \$150,000 to \$250,000 per year over the first 3 years of employing a physician — owing in part to a slow ramp-up period as physicians establish themselves or transition their practices and adapt to management changes. The losses decrease by approximately 50% after 3 years but do persist thereafter. New primary care physicians (PCPs) contribute nearly \$150,000 less to hospitals than their more-established counterparts; among specialists, the difference is \$200,000. For hospitals to break even, newly hired PCPs must generate at least 30% more

visits, and new specialists 25% more referrals, than they do at the outset. After 3 years, hospitals expect to begin making money on employed physicians when they account for the value of all care, tests, and referrals. Skeptics note that often they already capture this value from physicians without employing them, through stable referral networks and hospital practice choices. Outpatient office practices of employed physicians seldom turn a profit for hospitals.

Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities. In the 1990s, hospitals usually guaranteed physicians nearly 100% of their previous year's salary during their transition to hospital employment. This arrangement invariably led to losses, since drops in productivity were coupled with higher overhead expenses and less-effective revenue-cycle management. Today, aggressive hiring of PCPs is returning, in part because hospitals fear physicians' becoming competitors by aggregating into larger integrated groups that direct referrals and utilization to their own advantage. Hospital-employed PCPs generally direct patients to their own hospitals and specialists affiliated with them. In addition, by employing physicians, hospitals retain maximum flexibility in the market, should health plans change their reimbursement structures to require providers to bear risk and manage population health.

Hospitals are clearly acquiring practices again (see Fig. 1). A recent survey by the Medical Group Management Association shows a nearly 75% increase in the number of active doctors

employed by hospitals since 2000, and recent hospital announcements suggest this trend is accelerating. A September 2010 survey revealed that 74% of hospital leaders planned to increase physician employment within the next 12 to 36 months.² Furthermore, the young doctors being hired today tend to value better work-life balance and are more willing than preceding generations to trade higher incomes for

the lifestyle flexibility and administrative simplicity provided by hospital employment. Whereas hospitals prioritized PCP employment in the 1990s, they are now targeting both PCPs and specialists (see Fig. 2); many organizations are constructing what could effectively become closed, integrated health care delivery systems.

Strategically, hospitals with a robust employment strategy will

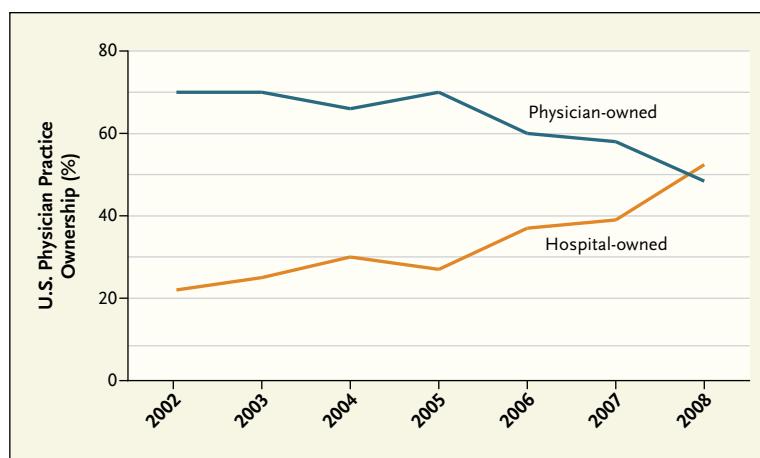


Figure 1. Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals, 2002–2008.

Data are from the Physician Compensation and Production Survey, Medical Group Management Association, 2003–2009.

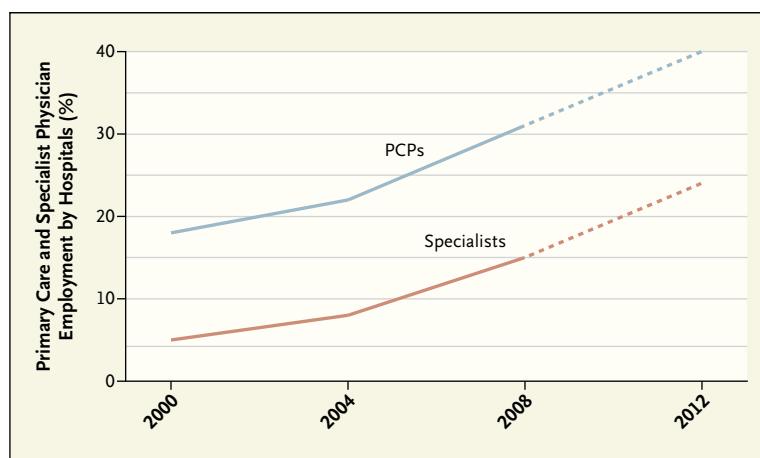


Figure 2. Percentages of Active U.S. Primary Care Physicians (PCPs) and Specialist Physicians Employed by Hospitals, 2000–2012.

Data are from the Physician Compensation and Production Survey, Medical Group Management Association, 2003–2009.

be well positioned to compete under various reimbursement scenarios. If the fee-for-service system persists, large physician networks will provide hospitals with greater pricing power when they are contracting with health plans. This scenario favors greater hiring of specialists. Conversely, if payment systems move toward population health management and risk-based reimbursement, then large outpatient networks will allow a system to shift patients away from higher-cost hospital-based care and recapture lost revenues as shared savings or capitation surpluses. This scenario favors greater hiring of PCPs.

A major concern in either scenario is the potential for hospitals to convert greater market power into higher prices and less competition.³ High-cost markets are typified by dominant local providers who exercise pricing power. This is perhaps most clearly illustrated in Massachusetts, where Attorney General Martha Coakley determined that high prices and price variation are largely correlated with market share. She found that "price variations are not explained by quality of care, the sickness or complexity of the population being served, the extent to which the hospital is responsible for caring for a large portion of patients on Medicare or Medicaid, or whether the hospital is an academic teaching or research facility."⁴ Payers acquiesce in price negotiations because they cannot afford to lose access to large provider networks. Similar patterns have emerged around the country; for instance, in Roanoke, Virginia, the dominant system, Carillion, reportedly charged 4 to

10 times as much for a colonoscopy as local competitors or providers in similar markets.⁵ Although ACO-type organizations that integrate physicians and hospitals offer the promise of better care coordination, fewer complications, and cost savings, it is unclear whether these benefits will be passed along to patients as lower prices.

In the future, physicians should anticipate a shift from guaranteed salaries to incentive-driven compensation linked to productivity and clinical behavior — with base compensation that is lower than their previous earnings but incentives that can increase it to that level or higher. This approach attempts to maintain productivity levels, while encouraging physician behaviors that reduce costs or increase revenues. Today, in markets where most physicians who are highly profitable to hospitals are free agents, hospitals tolerate higher operating costs in order to attract and retain these physicians' loyalty. As more physicians become employees, hospitals will be better able to reduce excess costs associated with unnecessary practice variation and unnecessarily expensive supplies selected by physicians. These reductions will be achieved through such actions as standardizing surgical supplies, using evidence to choose cost-effective medical devices, requiring use of health information technology, requiring adherence to clinical guidelines, scheduling elective procedures in ways that maximize asset utilization, and discharging patients consistently early in the day. Although some physicians may not want to trade autonomy for employment, they must un-

derstand that hospitals are under pressure to implement cost-saving strategies, which may benefit consumers if savings are passed on through lower prices.

Understanding the economics of physician employment and the actions hospitals will probably take to stem losses will help physicians make wiser judgments. Hospital owners will not engage in long-term strategies that lose money indefinitely. Though hospital employment may offer physicians some protection from system reforms, it comes with more performance management than it once did, and the option of reverting to independent practice later may be far less attractive in the future. Employment choices that physicians make today may not be able to be undone.

Of course, these choices will also affect patients. As patients accumulate more, and more complex, medical conditions, their care will require greater coordination, greater use of clinical data, and collaborative provider teams — which integrated delivery systems are best positioned to deliver. In the long run, any pricing distortions derived from market power and friction associated with changing the role and behaviors of physicians are likely to dissipate and be outweighed by improved productivity, outcomes, and patient experiences, and more efficient health care markets may translate into lower prices over time.

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