

THE STATE OF INDEPENDENT MEDICAL PRACTICE

**A Report to the Physicians' Foundation
For Health Systems Excellence**

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THE STATE OF INDEPENDENT MEDICAL PRACTICE

EXECUTIVE SUMMARY

The purpose of this report is to provide the Physicians' Foundation for Health Systems Excellence) with an overview of the current state of independent medical practice, which we define as a practice that is owned by the physician or physicians who work there.

In the report, we review what is known about the current state of independent practice; recent trends in independent practice; the forces that lie behind those trends; and what impact those trends appear to be having on patient care, as well as on physicians themselves.

Current status

The most recent national estimates put the current proportion of independent physicians at anywhere from more than half of all practicing physicians (American Medical Association and the Center for Studying Health System Change) to about one quarter (Bureau of Labor Statistics), depending on the definitions and sampling frame used and on how the surveys are administered. The Center's and the AMA's surveys ask physicians directly, whereas the Bureau of Labor Statistics asks the *households* of physicians, including those who practice as little as one hour a week. Because of the potential unreliability of answers by household members, the surveys showing higher percentages of independent practitioners are probably more accurate. Practice ownership appears to be higher among surgical specialists than among medical specialists and primary care physicians.

We were somewhat surprised to learn that self-reported clinical autonomy (another way to think about independent practice) remains quite high (around 90 percent) among both independent and employed physicians, and may even be higher among employed physicians—perhaps because they are more insulated from the realities of the market than their colleagues in independent practice.

Trends

Linking the data from several surveys over time, it appears that independent medical practice has been in fairly steady decline for at least the past 25 years, dropping at a rate of roughly 2 percent a year. Reports from the field suggest that, in some parts of the country, especially in rural areas, the decline in small independent primary care practices is reaching crisis proportions, although at the national level it appears that the rate of decline in independent practice has actually been greater among specialists than among primary care physicians. (Between 1996-1997 and 2004-2005, the proportion of primary care physicians with an ownership stake in their practice fell by only 2.5 percentage points, compared with 7.4 percentage points for surgical specialists and 10.8 percentage points for medical specialists.)

The reasons behind the decline in independent practice are complex. Among specialists, the decline may in part be driven by the renewed efforts of hospitals and other large organizations to snap up lucrative specialty practices that they believe will add to their bottom line. But at a more fundamental level, it appears that it is the combined effect of both public and private-sector payers aggressively seeking to clamp down on ever-rising health care costs—through managed care and other reimbursement controls—that has been the major driver in the weakening of independent practice. The problem is exacerbated by the fact that independent physicians have been precluded from mounting any real counter-offensive at the contract negotiating table by the disadvantages that they face under the antitrust laws.

The result has been a flattening—or even a decline—of practice revenues, especially in primary care and the cognitive specialties, coupled with steadily rising practice costs and ever-growing administrative burdens. Some procedural specialists, on the other hand, seem to be doing well financially, especially those who have formed or joined mid-sized single-specialty practices that enable them to spread some of their overhead costs.

Along with these economic forces, certain demographic trends have also had an impact on independent practice, most notably the continuing increase in the proportion of women in medicine. Many women physicians, and increasingly many men now entering practice, appear to prefer the relative financial security and the shorter hours that come with a salaried position in a large organization, even if it means making less money and having less of a decision-making role than they might in an independent practice.

Moreover, changes in the practice of medicine itself may be contributing to the decline of independent practices, at least solo and small independent practices. The complexity of providing and coordinating care for chronically ill patients with multiple conditions, the problems in keeping up and complying with various practice guidelines, and the cost and difficulty of installing electronic medical records systems can motivate physicians to join larger practices and organizations.

Impact of the decline

In reviewing the literature comparing outcomes for independent physicians with those for employed physicians, we didn't find much solid information. While a number of studies looked at various aspects of quality of care, the evidence is both ambiguous and incomplete.

And although there was some evidence to suggest that patients tend to trust independent physicians more than they do salaried physicians and that independent physicians are more likely to provide charity care than salaried physicians, the data on these outcomes are even more limited than they are on quality. Furthermore, our interviews with

knowledgeable observers in the field suggest that there may be additional, potentially important outcomes such as productivity, cost-effectiveness, and rural access on which the impact of independent practice has hardly been studied at all.

The upshot is that when it comes to understanding the societal impact of the decline in independent practice, we are still largely flying blind.

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Prepared by Isaacs/Jellinek, August 2008

OVERVIEW

The purpose of this report is to provide the Medical Association of Physicians Foundation for Health Systems Excellence (Foundation) with an overview of the current state of independent medical practice and the issues faced by independent physicians in today's turbulent health care environment. The report is based on a review of the relevant literature and on a series of interviews conducted with knowledgeable observers in the field, including independent analysts and researchers and practicing physicians.

After a brief discussion of what constitutes independent practice, we review what is known about the current status of independent practice, what some of the recent trends have been, what lies behind those trends, and what impact those trends appear to be having on patient care and on physicians themselves.

DEFINING INDEPENDENT PRACTICE

For the purposes of this report, an *independent practice* is defined as a practice that is owned by the physician or physicians who work there (although such a practice may also include salaried physicians). Along the same lines, an *independent physician* is defined as a physician who owns, either alone or in partnership with other physicians, his or her practice. This is the concept of physician independence that is monitored by the Bureau of Labor Statistics,¹ the American Medical Association,² and the Center for Studying Health System Change,^{3*} the three principal data sources that monitor physician ownership and employment trends. The Bureau of Labor Statistics and the American Medical Association generally classify physicians who have an ownership stake in their practice as "self-employed," and so we shall use that designation interchangeably with "physician-owned."

* The Center for Studying Health System Change is a non-partisan policy research organization located in Washington, DC, and launched in the mid-1990's with major funding from the Robert Wood Johnson Foundation, which remains its principal sponsor. The Center is affiliated with Mathematica Policy Research, Inc.

However, while independent practice is defined in terms of ownership for the purposes of this report, another important way to think about the concept of independent practice is in terms of *clinical autonomy*. That is, regardless of practice ownership or employment status, how free is the physician to do what he or she thinks is best for the patient?

For a variety of reasons, clinical autonomy is more difficult to measure and to monitor than practice ownership, but for many physicians, it may be as important. In a study published in the *Journal of the American Medical Association* that explored the factors associated with career satisfaction among primary care and specialist physicians, researchers found that “the strongest and most consistent predictors of change in [physician] satisfaction were changes in measures of clinical autonomy.”⁴

Data from the 2000-01 Physician Survey by the Center for Studying Health System Change also suggest that clinical autonomy is highly valued by physicians involved in direct patient care. Asked “how important is control over your clinical decisions,” 90.7% of the physicians surveyed responded that it was “very important.” In contrast, only 42.3% responded that their potential income was “very important,” and 48.3% responded that control over their practice’s business decisions was “very important.”⁵

It is important to note that practice ownership does not necessarily guarantee clinical autonomy. For example, a group of physicians might own their practice, but if a large share of their revenues comes from restrictive managed care plans—or from a highly prescriptive pay-for-performance program—their clinical autonomy could in fact be compromised.[†] The same could be true if the practice participates in an aggressively managed independent practice association. Consequently, in order to fully understand what is happening to physician independence, it will be necessary to look beyond ownership and self-employment data at measures of clinical autonomy and the factors that influence it.

Finally, a word about practice size. While small practices are not necessarily independent and independent practices are not necessarily small, there appears to be a substantial overlap between the two. The most recent available national data, from 2004-05, indicate that roughly 80% of independent physicians who are involved in direct patient care for at least 20 hours a week work in practices of 10 or fewer physicians, compared with only 17% of employed or salaried physicians. And if we look at the smallest practices, we find that more than half of all independent physicians (51.7%) work in solo or two-physician practices, compared with only one in ten (9.6%) of salaried physicians.⁶ We make this point because often data on practice size may be more readily available than data on practice ownership, and while those data cannot be used interchangeably, there does appear to be a fairly strong correlation between ownership and size.

[†] Based on data from the 2000-01 Physician Survey conducted by the Center for Studying Health System Change, 90.8% of the nation’s actively practicing physicians had at least one managed care contract, and among those who had managed care contracts, an average of 46% of their practice revenues came from those contracts (up from 43% in 1996-97). One physician we spoke with observed that “most small independent practices are already de facto employees of the managed care companies. They’re independent in name only.”

CURRENT STATUS

Ownership

According to the most recent data currently available from the Center for Studying Health System Change, in 2004-05 *more than half (54.4%) of non-federal U.S. physicians who provided patient care at least 20 hours a week were full or part owners of their practice.* The proportion was highest for surgical specialists (68.4%), followed by primary care physicians (51.8%) and medical specialists (47.3%)[‡] (Table 1).⁷

Table 1

Percentage of U.S. Physicians Who Were Owners/Part-Owners in 2004-05

All physicians	54.4%
Primary care physicians	51.8
Medical specialists	47.3
Surgical specialists	68.4

Source: Center for Studying Health System Change

The most recent data currently available from the American Medical Association come from the 2001 Patient Care Physician Survey. That survey found that self-employed physicians—defined as “those who have an ownership interest in their practice”—accounted for 61.5% of all physicians.⁸ This figure is somewhat higher than the Center for Studying Health System Change figure for the same period (55.9% of all physicians in 2000-01),⁹ but the data from the two surveys are at least in the same ballpark.

This is not the case for the Current Population Survey, which is used by the Bureau of Labor Statistics. The Current Population Survey is the most up-to-date of the currently available sources, but its figures on the proportion of self-employed physicians are considerably lower than those from the Center for Studying Health System Change or the

[‡] Medical specialties include cardiology, dermatology, emergency medicine, gastroenterology, neurology, oncology, psychiatry, pulmonology, and “other”. Surgical specialties include general surgery, OB/GYN, ophthalmology, orthopedics, otolaryngology, urology, and “other.”

American Medical Association. For 2001, the most recent year for which we have data from all three sources, the Current Population Survey reported that 29.3% of all physicians and surgeons were self-employed,⁸ which is only about *half* the proportions reported by the Center for Studying Health System Change and the American Medical Association for that same year (Table 2).¹⁰ For 2007, its most recent year, the Current Population Survey reports that only 25.9% of all physicians and surgeons were self-employed—again, less than half the 54.4% figure reported by the Center for Studying Health System Change just a few years earlier (2004-05).¹¹

Table 2

Percentage of U.S. Physicians Who Were Owners/Part-Owners, 2001, By Data Source

American Medical Association PCPS	61.5%
Center for Studying Health System Change (2000-01)	55.9
Bureau of Labor Statistics CPS	29.3

In seeking to understand the reason for these differences, we spoke with staff at the Center for Studying Health System Change and the Bureau of Labor Statistics.¹² Part of the difference may have to do with who is included in the sample. As noted above, the Center for Studying Health System Change includes only physicians who provide patient care at least 20 hours a week, while the Current Population Survey sample includes all physicians who practice at least *one* hour per week. This would include, for example, physicians in academic or administrative positions who still practice part-time, but less than 20 hours a week. In general, such physicians are probably more likely to be employees of their institutions rather than “self-employed.”

The Center for Studying Health System Change also does not include specialties not generally involved in direct patient care, such as pathology or radiology, and does not include federally employed physicians, residents, fellows, or physicians in Alaska or Hawaii in its survey.¹³ Finally, while the Center for Studying Health System Change and the American Medical Association survey physicians directly, the Current Population Survey is a household survey, and therefore may be getting its information from family members or others in the household who are not as familiar with the intricacies of ownership and “incorporated self-employed” vs. “self-employed” status (the Current Population Survey distinguishes between these two sub-categories) as the physicians themselves. This, too, may help to explain the significantly lower rates of “self-employed” physicians reported in the Current Population Survey.

⁸ The Current Population Survey distinguishes between “self-employed” and “incorporated self-employed.” For purposes of comparability with the other data sources, we have combined these two sub-categories into a single “self-employed” category.

Whatever the technical reasons, the practical implications are very real. For those concerned about the status of independent practice (including the Foundation), it presumably makes a considerable difference whether more than half the nation's physicians are still in independent practice, as the American Medical Association and Center for Studying Health System Change data suggest, or only one in four, as reported in the most recent Current Population Survey.

Furthermore, because the Current Population Survey is the only major *federal* data source that reports the proportion of self-employed physicians, it may carry special weight with federal policy makers and agency staff. That said, in speaking with staff at the Bureau of Labor Statistics, we were told that, in their opinion, those surveys that directly ask physicians about their ownership status probably obtain more accurate responses than the Current Population Survey, which asks household members.

We should add that while at this time the most recent ownership/self-employment data available are from the 2007 Current Population Survey, both the American Medical Association and the Center for Studying Health System Change are currently (2007-08) conducting new surveys that should provide updated information from physician respondents. The American Medical Association's Physician Practice Information Survey, which is being conducted in collaboration with more than 70 medical specialty societies, is its first major field survey of this kind in almost a decade, and will look at "both the clinical and business side of medical practice."¹⁴ The Center for Studying Health System Change is conducting its fifth Physician Survey since 1996-97 (the most recent was in 2004-05), and thus will provide valuable trend data.¹⁵ Findings from the American Medical Association's survey are expected to become available in 2009;¹⁶ results of the Center for Studying Health System Change survey will probably become available in late 2009 or early 2010.¹⁷

Clinical Autonomy

The most recent national estimates we have of the level of clinical autonomy among physicians come from the public use file for the 2004-05 Physician Survey conducted by the Center for Studying Health System Change.¹⁸ In response to the statement “I have the freedom to make clinical decisions that meet my patients’ needs,” almost 9 out of 10 respondents (87.1%) agreed. More specifically, 54.6% of the physicians surveyed strongly agreed, and another 32.5% agreed somewhat. Only 2.8% disagreed strongly; another 8.4% disagreed somewhat; and the remaining 1.5% neither agreed nor disagreed (Table 3).

Table 3

2004-05 Physician Survey Responses to Statement: “I have the freedom to make clinical decisions that meet my patients’ needs.”

Strongly agree	54.6%
Agree somewhat	32.5
Neither agree nor disagree	1.5
Disagree somewhat	8.4
Strongly disagree	2.8

Source: Center for Studying Health System Change

In reviewing these data, we were struck by the finding that the proportion of physicians who agreed that they have the freedom to make clinical decisions that meet their patients’ needs (87.1%) was more than 30 percentage points higher than the proportion of physicians in the same survey who reported that they were owners or part-owners of their practice (55.9%). This clearly suggests that many physicians who do not have an ownership stake in their practices nevertheless do believe that they have the clinical autonomy to do what they believe is in the best interest of their patients.

To explore this phenomenon in greater depth, we requested that the Center for Studying Health System Change generate a cross-tabulation for us, breaking out their clinical autonomy findings by practice ownership status (Table 4).¹⁹

Table 4

2004-05 Physician Survey Responses to Statement: “I have the freedom to make clinical decisions that meet my patients’ needs,” By Practice Ownership Status

	Full owner	Part owner	Non-owner
Strongly agree	46.8%	55.0%	61.7%
Agree somewhat	36.6	31.7	29.2
Neither agree/disagree	1.6	1.2	1.2
Disagree somewhat	10.9	8.7	5.6
Disagree strongly	3.8	3.4	1.7

Source: Center for Studying Health System Change

The results of the cross-tabulation were surprising to us, indicating that physicians who did *not* have an ownership stake in their practice (that is, employed physicians) were actually *more* likely than physicians with an ownership stake to report that they agreed with the statement that “I have the freedom to make clinical decisions that meet my patients’ needs.” Specifically, 90.9% of non-owners agreed with this clinical autonomy statement, compared with 84.8% of physicians with an ownership stake in their practice (86.7% of part-owners and 83.4% of full owners)—a difference of about 6 percentage points.

That 6 point gap almost doubles to over 11 percentage points when looking only at those respondents who *strongly* agreed: 61.7% of non-owners strongly agreed with the clinical autonomy statement, compared with only 50.3% of physicians with an ownership stake in their practice. And when we zero in on the proportion of *full* owners who strongly agreed that they have the freedom to make clinical decisions that meet their patients’ needs (46.8%), that gap widens to almost 17 percentage points. In other words, according to these findings, actively practicing physicians who are full owners of their practice are substantially *less* likely than employed physicians to report that they have the clinical autonomy to do what they believe is best for their patients.

In a personal communication,²⁰ James Reschovsky of the Center for Studying Health System Change offered three possible explanations for this surprising (to us) result (presented in his words):

1. There is a certain amount of self-selection in who becomes owners vs. employees. Owners are more likely to value autonomy (clinical or otherwise) and hence

- might have different standards in answering this question. This is particularly the case for solo docs, who are different from other physicians across many dimensions.
2. Employees are somewhat sheltered from health plan financial incentives and care restrictions by practice organizations, but owners are more aware of these things as they make contracting decisions, and their incomes are more directly affected by health plan contracts.
 3. Larger practices (which have more employees, fewer owners) have greater bargaining power vis a vis health plans and may be able to negotiate less restrictive contracts.

TRENDS

Ownership trends

In looking at what the trends in practice ownership have been, we found that the proportion of patient care physicians in the United States with an ownership stake in their practice appears to have been declining for at least the past 25 years. While no single survey has consistently been tracking practice ownership over that 25-year period, we were able to piece together the general trend since 1983 with data from the American Medical Association’s Socioeconomic Monitoring System (1983 through 1994), the Center for Studying Health System Change Physician Survey (1995-96 through 2004-05), and the Bureau of Labor Statistics Current Population Survey (2000 through 2007).** As discussed earlier, these three surveys use different definitions and samples, and so their findings cannot be linked into a single continuous trend line from 1983 to 2007. However, the fact that each of the three surveys found that practice ownership was declining during the period that it covered gives us a composite picture that strongly suggests that the overall trend in practice ownership during the past 25 years has been negative (Table 5).

Table 5

Average Annual Rate of Decline in the Proportion of Physicians
With an Ownership Stake in Their Practices, 1983-2007

1983 to 1994 (American Medical Association)	2.2%
1996-97 to 2004-05 (Center for Studying Health System Change)	1.5
2000-07 (Current Population Survey)	2.0

** According to staff at the Bureau of Labor Statistics, there was a change in the Current Population Survey with respect to this item that was instituted in the year 2000, which is why these trend data from the CPS are only presented beginning in 2000.

Specifically, based on responses to the American Medical Association's Socioeconomic Monitoring System surveys of nonfederal post-resident patient care physicians, Kletke, Emmons and Gillis, in a 1996 article aptly entitled "Current Trends in Physician Practice Arrangements: from Owners to Employees," reported that "between 1983 and 1994, the proportion of patient care physicians practicing as employees rose from 24.2% to 42.3%, ...[while] the proportion self-employed in solo practices fell from 40.5% to 29.3%... and the proportion self-employed in group practices fell from 35.3% to 28.4%."²¹ Combining the data for self-employed solo and group practice physicians in these surveys, this means that the proportion of physicians with an ownership stake in their practices fell from 75.8% in 1983 to 57.7% in 1994. This constitutes an average annual rate of decline of 2.2% during this eleven-year period, although significantly, Kletke and his colleagues note that "most of these changes occurred in the latter half of the 12-year period."

The Center for Studying Health System Change, using a somewhat different definition and sample than the American Medical Association, reported that the proportion of nonfederal patient care physicians who provided direct patient care at least 20 hours a week and who were owners or part-owners of their practice declined from 61.1% in 1996-97 to 54.4% in 2004-05.²² While these proportions appear to be somewhat higher than the proportions reported by the American Medical Association—probably because of the differences in the definitions and samples used—the trends in the two surveys are in the same downward direction. The average annual rate of decline between 1996-97 and 2004-05 was only 1.5%, somewhat slower than the annual rate of 2.2% between 1983 and 1994. But again, it is important to look at the changes *within* that 8-year period. During the initial two-year period from 1996-97 to 1998-99, the average annual rate of decline stood at a very high 4.0%, tapering off to an average annual rate of decline of only 0.7% for the remaining six years between 1998-99 and 2004-05.

Finally, the Current Population Survey, which uses yet another set of definitions and samples, found that the proportion of self-employed physicians (including incorporated as well as unincorporated self-employed)²³ declined from 30.1% in 2000 to 25.9% in 2007, which represents an annual rate of decline of about 2.0%. Looking more closely at the year-by-year data, it appears that there was actually a very small increase in the proportion of self-employed physicians between 2001 and 2003 (from 29.3% to 30.4%), but the downward trend picked up again in each of the following years, consistent with the overall trend over the past twenty-five years (Table 6).²⁴

We should note that the average annual rate of decline reflected in the Current Population Survey data for 2001 to 2005 (2.0%) is considerably higher than the rate reflected in the Center for Studying Health System Change data for the same period (0.7%). The reasons for this difference are not immediately apparent.

Table 6

Proportion of Self-Employed Physicians and Surgeons (Incorporated and Unincorporated), Current Population Survey, 2000-07

2000	30.1%
2001	29.3
2002	29.9
2003	30.4
2004	27.1
2005	27.0
2006	26.7
2007	25.9

Source: Bureau of Labor Statistics

Reports from the field

Along with these national trend data, there are reports from the field indicating that practice ownership has been declining at the regional level. For example, in a series of stories last fall about coping with tough markets, *Medical Economics* singled out the state of Maine as a particularly difficult environment for independent physicians: “In the cities of Waterville, Bangor and Augusta... a growing number of doctors, in both primary care and the specialties, have begun working for hospital-owned practices or federally qualified health centers. In the more prosperous coastal cities of Portland, Saco, Biddeford, and Kennebunk, physicians have not only been leaving small independent practices to work for hospitals but, more typically, to join large private practice single- and multi-specialty groups. The trend away from independent practice, especially among primary care physicians, has alarmed some of the state’s elected officials.”²⁵

Another story in the same series, entitled “Doctors Struggle With Staying Independent,” focuses on western North Carolina and reports that “with hospitals in North Carolina heavily recruiting, physicians face the hard choice of whether or not to sell their practices.” The story goes on to say that although hospitals and large health care systems are buying up physician practices, they are no longer paying “the inflated prices that were typical in the 1990’s,” and quotes an Asheville-based healthcare consultant, Michael

Brady, who observes, “Given low reimbursements and high overhead, doctors are in more of a desperate mode these days. They’ll accept almost any money they can get to relieve themselves of some of the burdens of trying to make ends meet.”²⁶

On the other hand, Sandy Bechtel, a seasoned health care consultant based in Burlington, Vermont, told us that her company has been receiving requests from physicians all over the country wanting to establish new independent practices. She added that of the many independent practices her firm has helped to launch in Vermont over the past ten years, to her knowledge not a single one has gone under.

Ownership trends in primary care and specialty practice

When we looked at national data on practice ownership from the Center on Studying Health System Change, we found that, at least between 1996-97 and 2004-05, *practice ownership was actually falling more rapidly among specialists than among primary care physicians.*²⁷ The proportion of primary care physicians with an ownership stake in their practice declined from 54.3% in 1996-97 to 51.8% in 2004-05, or only 2.5 percentage points, while among medical specialists the proportion fell from 58.1% to 47.3% (10.8 percentage points) during that same period, and among surgical specialists the proportion fell from 75.5% to 68.4% (7.1 percentage points). Although the proportion with an ownership stake in their practice still remained significantly higher among surgical specialists than among primary care physicians, by 2004-05 a smaller proportion of *medical* specialists had an ownership stake in their practice (47.3%) than did primary care physicians (51.8%). (Table 7)

Table 7

Physicians Who Are Full/Part Owners, By Specialty, 1996-97 to 2004-05

	1996-97	2004-05
Primary Care	54.3%	51.8%
Medical Specialists	58.1	47.3
Surgical Specialists	75.5	68.4

Source: Center for Studying Health System Change

Trends in clinical autonomy

Data on trends in clinical autonomy are spottier than data on ownership trends, but those data that are available suggest that physicians' perceptions of their clinical autonomy have been strongly influenced by trends in managed care. A 1999 study of physicians in California, which was heavily impacted by managed care during the mid-1990's, found that "perceived levels of autonomy fell markedly between 1991 and 1996. In the 1996 age-matched sample, significantly fewer physicians reported that they had the freedom to spend sufficient time with their patients, hospitalize patients, carefully review histories and tests, care for patients unable to pay, order tests and procedures whenever they wanted to, and care for patients who required heavy use of time and resources. In most cases, the proportion of physicians reporting that they had autonomy fell by ten to twenty points."²⁸

At about the same time (1996-97), with managed care at or near its peak in many places, the Center for Studying Health System Change collected national data indicating that there was a significant gap in perceived clinical autonomy between primary care physicians and specialists, with 85.5% of the primary care physicians surveyed agreeing that they had the "freedom to make clinical decisions that meet patient needs," compared with only 72.7% of specialists. But just four years later, in 2000-01, that gap had essentially closed, as the proportion of specialists agreeing with the clinical autonomy statement rose to 85.7% while the proportion of primary care physicians essentially remained stable at 86.2%.²⁹ (Table 8)

Table 8

Proportion of Primary Care and Specialty Physicians Agreeing That They Have the "Freedom to Make Clinical Decisions That Meet Patient Needs," 1997-2001

	1997	1999	2001
Primary Care Physicians	85.5%	83.5%	86.2%
Specialists	72.2	76.7	85.7

Source: Center for Studying Health System Change

In their report describing these trends, Hargraves and Pham attribute the rise in perceived clinical autonomy among specialists to the managed care backlash of the late 1990's, which prompted many health plans to begin "easing restrictions on care and offering broader provider networks, making it easier for patients to access specialists."³⁰ More recent data from the Center for Studying Health System Change Physician Survey from 2004-05 (Table 3) indicate that physicians' perceptions of their clinical autonomy remained at roughly the same high level (87.1%) for at least the following four years.

WHY INDEPENDENT PRACTICES HAVE DECLINED

The payers take charge

In large part, the decline in physician independence can be traced to the run-up in health care costs that began in the mid-1960's following the enactment of Medicare and Medicaid, and the resulting efforts to control those costs by reducing utilization and keeping reimbursement rates low, especially through the use of managed care.³¹

Beginning in the early 1970's, the federal government took a variety of steps to try to slow the escalation of health care costs, including passage of the HMO Act of 1973 to encourage the growth of capitation through health maintenance organizations;³² the granting of Section 1115 waivers allowing states to enroll Medicaid beneficiaries in managed care; and the adoption of Diagnosis-Related Groups by the Medicare program in an effort to contain the rapid rise in hospital costs.

Meanwhile, at the state level, California passed legislation in 1982 permitting insurers to enter into contracts with selected providers who agreed to accept their rules and fee schedules (while excluding those who didn't), thereby laying the legal groundwork for the development of preferred provider organizations (PPO's).³³

But it wasn't until after the failure of the Clinton Administration's health care reform proposal in 1994 that the brakes were finally applied in earnest, largely by private sector employers who, having faced annual premium increases as high as 18% in the late 1980's,³⁴ began to embrace managed care on a far wider scale than they had in the past.

In 1988, 73% of Americans with private health insurance were enrolled in conventional fee-for-service plans, and only 27% were in some form of managed care. By 1996, just eight years later—and two years after the collapse of the Clinton health plan—those proportions had been reversed: only 27% of privately insured Americans remained in fee-for-service plans, while the other 73% were enrolled in various forms of managed care, including HMO's (31%), PPO's (28%), and point of service plans (14%). And by 2005, the most recent year for which these data are currently available, traditional fee-for-service had virtually disappeared: only 3% of those with private health insurance remained in conventional fee-for-service plans.³⁵ (Table 9)

Table 9

Private Health Insurance Enrollment,
By Plan Type, 1988-2005

	Conventional Fee-For-Service	HMO	PPO	POS
1988	73%	16%	11%	0%
1996	27	31	28	14
2001	7	23	48	22
2005	3	21	61	15

Source: Centers for Medicare and Medicaid Services

This rapid movement of large numbers of employees from traditional fee-for-service coverage into managed care plans signaled a profound shift in the balance of economic power within the nation's health care sector. *Suddenly, it was the payers rather than the providers themselves who were determining how much the providers would be paid for their services.* And it is worth noting that while the payers that the physicians dealt with were generally the managed care plans (these days more often referred to as "health plans" because of the negative stigma associated with "managed care"), the true payers were the employers, whose business the managed care plans had to compete for—sometimes quite aggressively—on the basis of price and value.³⁶

Looking for leverage

Faced with this bewildering new world of managed care, many physicians, especially in markets with high managed care penetration, began looking for ways to gain at least some degree of leverage in their negotiations with the managed care plans. But many of them—especially those in small independent practices, who were often in the weakest negotiating position—quickly ran up against federal anti-trust provisions.

As David Hsia, MD, JD, points out in a 2001 editorial in the *Annals of Internal Medicine*, "Independent physicians, because they are individual firms and not employees, fall under the anti-trust laws' prohibition against restraint of trade." This is especially problematic, Hsia says, because while there are many independent physicians in most health care

markets, there are usually only a limited number of managed care plans within those same markets, giving those plans disproportionate market power and negotiating clout.³⁷

A recent story in *Medical Economics* cites the example of Philadelphia, where Independence Blue Cross reportedly controls almost 70% of the combined HMO/PPO market, and quotes Eric E. Shore, MD, JD, an internist and lawyer who used to practice in Philadelphia: “It’s no secret that these contracts are presented [by Independence Blue Cross] on a ‘take-it-or-leave-it’ basis. Given IBC’s market share, doctors can’t really exercise the ‘leave it’ option, so they’re forced to accept whatever terms are offered, regardless of their fairness or how they’re applied.”³⁸

A physician we spoke with reported similar market conditions in Hawaii, where Blue Cross and Kaiser together cover upwards of 90% of the insured population. “The doctors have no say,” he told us. “Starting salary for a primary care physician at the Kauai Medical Clinic is \$60,000. A dock worker gets \$150,000.”

Over the years, a variety of bills designed to provide anti-trust relief to physicians have been introduced at the state and federal level,³⁹ up to and including the “Quality Health Care Coalition Act of 2007” (H.R. 3341), which was introduced by Rep. Ron Paul (R-TX) in August of 2007.⁴⁰ But so far, these bills have not made much headway, both because of strong opposition from the insurance industry, and because some lawmakers are concerned that such provisions could fuel further increases in already escalating health care costs.

The IPA option

Blocked from overt collective bargaining by anti-trust laws, one option for independent physicians was to form or join an independent practice association (IPA). An IPA is a legal entity organized and directed by independent physicians that seeks to harness the collective market power of a large number of independent practices in order to negotiate more favorable contracts with health plans and other payors.

But as Jeffrey King, an attorney with extensive health care experience, has pointed out, the formation and operation of an IPA raises a host of legal issues, including licensure and choice of entity; illegal remuneration; self-referral; HMO insurance regulations; the use of utilization review agents; securities law; benefit plans; liability; and, of course, anti-trust provisions.⁴¹

Moreover, while the participating physicians retain ownership of their practices, they may well lose some of their clinical autonomy. A January 2000 story in the *Denver Post* describes the frustration of one family physician who joined a Denver-area IPA: “[He] said it was bad enough for HMO’s to try tell him how to do his job. But when his own colleagues took over that role, it was intolerable.”⁴²

While some independent physicians did join IPA's, those who chose not to and who wanted to remain in practice were left with essentially two options: (1) joining (or creating) a larger practice or other health care organization with greater negotiating clout, which often meant becoming an employee, or (2) battenning down the hatches and toughing it out as an independent practice. Bearing in mind the point made earlier in this report about the correlation between practice size and practice ownership, Table 10 suggests that both occurred.⁴³

Table 10

Distribution of Physicians, By Practice Setting, 1996-97 to 2004-05

	1996-97	2000-01	2004-05
Solo/2-physician practices	40.7%	35.2%	32.5%
Practices of 3-5 physicians	12.2	11.7	9.8
Practices of 6-50 physicians	13.1	15.8	17.6
Practices of 50+ physicians	2.9	2.7	4.2
Medical schools	7.3	8.4	9.3
HMO's	5.0	3.8	4.5
Hospitals/hospital-owned practices	10.7	12.0	12.0
Other (CHC, clinic, contractor)	8.3	10.4	10.1

Source: Center for Studying Health System Change

On the one hand, the reduction in the proportion of physicians in solo and smaller practices (which tend to be comprised of independent physicians), coupled with the increases in the proportion in larger practices, hospitals and medical schools, suggests that a growing number of physicians did opt for the relative security and negotiating leverage of larger groups and institutions—including both established physicians who changed where they practiced and young physicians just entering practice (although it is also possible that a number of physicians in small practices may have given up medical practice entirely).

On the other hand, the fact that the proportion of physicians in small practices (1 to 5 physicians) fell from 52.9% in 1996-97 to 42.3% in 2004-05 means that about 80% of those who were in the smaller practices in 1996-97 chose to *remain* in their small practices during this 8-year period, despite steadily rising practice costs and declining revenues. As one physician we spoke with put it, “The fact that a moderately large number of doctors are still independent tells me the sky isn’t necessarily falling.”

The managed care roller coaster

While a growing number of both primary care and specialty physicians have sought strength in numbers in the face of managed care, there have been some important differences in the ways that managed care has impacted primary care versus specialty physicians.

When managed care first took off in the mid-1990’s, many of the contracts were fully or at least partially capitated. This placed those providers who contracted with managed care at financial risk and created powerful incentives for them to control the use of high-cost specialists and specialty procedures. In fact, under these capitation contracts, those provider organizations that could truly clamp down on the use of costly specialty care stood to make a tidy profit.

The result was a rapid proliferation of physician-hospital organizations, for-profit practice management corporations, and large multi-specialty physician groups that relied on primary care physicians to generate referrals and to control utilization and costs. Suddenly, primary care physicians were in high demand, as hospitals and other organizations seeking to develop vertically integrated systems of care began scooping up primary care practices in record numbers.⁴⁴

But this buying spree was short-lived. By the late 1990’s, a powerful public backlash against the rigors of capitated managed care had taken hold,⁴⁵ and with the national economy booming and labor markets tight, capitated managed care soon gave way to a “kinder and gentler” version of managed care⁴⁶ in which primary care gatekeepers played much less of a role (if any), and specialists were once again paid on what amounted to a fee-for-service basis—albeit at considerably lower rates than the “usual and customary” rates they had received during the golden years of conventional fee-for-service reimbursement.⁴⁷

Still, despite the weakening of managed care controls, many physicians were losing ground financially. With the major health plans, as well as Medicare and Medicaid, using their overwhelming market muscle to keep reimbursement rates low, and with practice expenses, including administrative costs and malpractice premiums, rising every year, the Center for Studying Health System Change reported that inflation-adjusted average income for all patient care physicians fell by 7.1% between 1995 and 2003.⁴⁸

Ironically, given the brief surge in demand for their services under capitated managed care, it was primary care physicians—who had the lowest incomes to begin with—who took the biggest hit, with a loss in real income of 10.2% between 1995 and 2003. Surgical specialists also lost substantial ground (8.2%), although they started from a significantly higher base than their primary care colleagues. Only medical specialists seemed to hold their financial ground reasonably well, with a loss of only 2.1%.⁴⁹

Rise of the mid-sized specialty groups

In the face of these economic pressures, a new phenomenon arose: the rapid growth and proliferation of mid-sized specialty practices, particularly among those specialties that could take advantage of the resurrected fee-for-service payment mechanism.

As Liebhaber and Grossman point out, “In a fee-for-service environment, in contrast to under risk-sharing arrangements, physicians had incentives to provide profitable procedures and ancillary services, such as high-end imaging and diagnostic testing. Procedure- and service-intensive specialties likely had more opportunities to benefit than other specialists or primary care physicians. Payment for these services is typically higher than for office visits, and the growing trend of physician-owned outpatient facilities”—and, we would add, physician-owned specialty hospitals—“provided opportunities for additional physician revenue. In this environment, physicians benefited from aggregating into larger single-specialty practices with greater capital and scale economies to invest in equipment and facilities to provide these services.”⁵⁰

They add that, “Single-specialty groups became more attractive [than multi-specialty groups or other vertically integrated gatekeeper models] because specialists could reap the advantages of group practice without having to redistribute income to primary care physicians... Single-specialty groups also had opportunities to gain negotiating leverage with health plans, while the referral advantages provided by multi-specialty groups waned as health plans eased referral restrictions.”⁵¹

The upshot, Liebhaber and Grossman indicate, was that “there was a much larger decrease in the percentage of owners among medical specialists and surgical specialists than among primary care physicians”—which is what the data in Table 7 show (page 20). This is another of the “surprising” findings that we encountered in our review of the field, since, on the face of it, it would appear that independent primary care physicians, with lower income levels and a greater rate of decline in their incomes than specialists, would be the first to seek the relative financial security of a larger entity and to give up their independence to become employees. But, as Table 7 shows, the reverse occurred.

In fact, in breaking out the trend data for primary care physicians in Table 7 into smaller segments, it turns out that while there was a net drop between 1996-97 and 2004-05 in the proportion of primary care physicians with an ownership stake in their practice, all of that drop actually occurred between 1996-97 and 1998-99. From 1998-99 to 2004-05, there was actually a slight *increase* in the proportion of independent primary care

physicians, from 49.6% to 51.8%, although this increase is not large enough to be statistically significant (Table 11).

Table 11

Primary Care Physicians Who Are Full/Part Owners, 1996-97 to 2004-05

1996-97	54.3%
1998-99	49.6
2000-01	50.1
2004-05	51.8

Source: Center for Studying Health System Change

If this increase *is* real and not just a statistical artifact, it may be the result of the dissolution of many of the multi-specialty groups, physician-hospital organizations and other vertically integrated entities that had recruited primary care gatekeepers during the mid-1990's and now had to let them go. In 2001, Craig Holm, a Philadelphia-based health care consultant who gave a seminar at the American College of Healthcare Executives annual meeting entitled "Ending Physician-Health System Partnerships Equitably," wryly observed that when hospitals did jettison the group practices they had acquired during the 1990's, many of them would have to "help [their employed physicians] learn what it's like to be in private practice."⁵²

Déjà vu all over again?

But the roller coaster ride didn't end there. Although many physician-hospital organizations and other vertically integrated systems were dissolved in the late 1990's and early 2000's as managed care weakened its grip somewhat, recent reports from the field indicate that hospitals are once again in the market for physician practices.

In 2005, for example, *Modern Healthcare* reported that Akron Children's Hospital in Akron, Ohio, was "busy snapping up selected physician practices and taking on the doctors as full-time employees." However, in contrast to the mid-1990's, this time the hospital was on the look-out for specialists, not primary care physicians. As Bob Howard, the hospital's director of planning explained, "We were faced with a choice of not having enough of the right types of specialists on our staff, or stepping up to the plate and doing something about it. We chose the latter."⁵³

It was the same story in other parts of the country. Kevin Kennedy, a management consultant, described how hospital CEO's in the Pacific Northwest were telling him that

physicians were showing up on their doorsteps, hat in hand, saying, “I can’t make it in this market anymore. If you don’t hire me, I’m going to move.” In response, Olympic Medical Center, a 209-bed hospital in Port Angeles, Washington, hired a general surgeon, an OB/GYN, an orthopedic surgeon, and four radiologists—the first time it had ever employed any physicians.⁵⁴

And a November 2007 report in *Medical Economics* indicates that, over the past two years, the demand for specialists has, if anything, intensified: “For a doctor weighing the opportunity to become a practice partner, it’s a buyers’ market. Physicians are now scarce in most specialties, and hospitals and large multi-specialty groups have stepped up their hiring. To remain competitive, small and medium-sized practices are offering better terms to job candidates, including higher salaries, reduced buy-in prices, and a shorter path to partnership.”⁵⁵

Just how this balance will play out in the coming years—between, on the one hand, hospitals and large groups that are *reducing* the number of independent physicians by employing them, and, on the other hand, small and mid-sized groups that are *adding* to the number of independent physicians by making it easier for them to acquire an ownership stake in their practice—remains to be seen.

The gender effect

While the changing economics of health care—especially with the advent of managed care in its various incarnations—has clearly been a major factor in the decline in independent physician practices, it is not the only one. Another important factor mentioned by many of the people we spoke with has been the steady increase in the proportion of women physicians. The following two statistics tell the story:

- In the year 2000, it was reported that 56% of women physicians were employees, compared with only 35% of male physicians.⁵⁶
- A 2005 report from the *New England Journal of Medicine’s* Career Center indicated that since 1975, the percentage of women physicians in the U.S. had almost tripled, from 9% to 25%.⁵⁷

The fact that women physicians are more likely than their male counterparts to be employees means that women are raising the proportion of employed physicians above what it would otherwise be. For example, based on these data, the higher rate of employment among women physicians in the year 2000 pushed the overall employment rate among all physicians approximately 5 percentage points higher than it would have been if women physicians had had the same employment rates as male physicians, from 35% to about 40%.^{††}

^{††} Conversely, one could say that the higher proportion of employed women physicians reduced the overall proportion of independent physicians in the year 2000 by about 5 percentage points, from 65% to 60%.

The added fact that the proportion of women physicians has been growing over the past 30 years means that their impact on the relative proportions of employed and independent physicians has been increasing over time. What's more, this impact is likely to continue to increase as the proportion of women physicians continues to grow. As the 2005 *New England Journal of Medicine* report notes, "The wave is far from cresting: 38% of doctors under age 44 are women, and half the students in U.S. medical schools are women, a change that is expected to intensify."⁵⁸

The report attributes the influx of women into medicine to two principal causes: the increased movement of women into professional careers, and the declining pool of male applicants to medical school. In explaining the dwindling pool of male applicants, the report notes, "Doctors' income has declined because of restrictions put in place by managed health care organizations and cutbacks in Medicare and Medicaid payments. As a result, many male college students are pursuing more financially rewarding careers, such as in business."⁵⁹ In other words, even the increase in the proportion of women in medicine—which on its surface appears to be purely a demographic phenomenon—may in part be driven by the same economic forces that have been having such a powerful direct impact on medical practice and practice ownership.

The age effect

Along with gender differences, there also appear to be age differences in ownership trends, although not much data on this appears in the literature. Liebhaber and Grossman, drawing on data from the Center for Studying Health System Change Physician Surveys between 1996-97 and 2004-05, report that although younger physicians are more likely than older physicians to be in larger groups and to be "non-owners" (employees), the gap narrowed between 1996-97 and 2004-05.⁶⁰

Specifically, they say, the proportion of physicians age 51 and older who were in solo or two-person practices fell from 51.5% to 38.8% during this period—a decline of 12.7 percentage points—while the proportion of physicians age 40 and younger in solo or two-person practices fell from 28.3% to 24.8%—a decline of only 3.5 percentage points, less than one-third the decline among older physicians. Moreover, most of the decline for younger physicians occurred between 1996-97 and 1998-99, while the decline for older physicians continued right on through 2004-05.

Although no data on ownership trends by age group are presented in their study, Liebhaber and Grossman do say that "the ownership trends mirrored the trends in practice type for each age group," meaning that although older physicians were more likely than younger physicians to have an ownership stake in their practices, practice ownership fell more sharply among older physicians than among younger physicians between 1996-97 and 2004-05.⁶¹

Why the decline in small independent practices has been so much greater among older physicians than younger physicians isn't entirely clear, unless it is that many older

physicians had established their practices under conditions that were considerably more favorable to small independent practices than they were by the time their younger colleagues set up shop several decades later. Health care consultant Sandy Bechtel told us that in order for an independent practice to make it in today's market, a physician has to be willing to "flip burgers"—meaning that he or she has to be willing to see a large number of patients, "probably about 24 a day." She said this was sometimes difficult for older physicians, who are accustomed to spending time with their patients and seeing only about half that volume.

Clinical complexity and information technology

In addition to the managed care tsunami, the gender effect and the age effect, another set of factors that many of the people we talked with cited when we asked them why they thought independent practice had been declining has to do with the challenges that many small independent practices face in coping with the growing burden of chronic illness. The complexities involved in providing and coordinating care for chronically ill patients, especially for those who present with multiple conditions, can stretch an already overworked small independent practice to its limits.

While electronic medical records and other forms of health information technology (such as chronic care registries) can be a great resource in the management of such patients and can sometimes provide entrée to pay-for-performance programs that offer enhanced reimbursement for adherence to evidence-based clinical protocols, purchasing and implementing such systems is generally far more difficult for small independent practices than it is for large groups or institutions. It is not surprising, therefore, that growing numbers of physicians who want to stay on the cutting edge of care and avail themselves of the clinical and financial advantages of health information technology are being drawn to organizational settings that can provide those resources.

IMPACT OF THE DECLINE OF INDEPENDENT PRACTICE: DOES IT MATTER?

While it is clear that the proportion of independent practices has been declining for some time now—and is continuing to decline—it is less clear just what the *impact* of this decline has been, both on patient care and on physicians themselves. How much does it really matter, and to whom?

Impact on quality

A small study by George Kikano of 108 family practices in northeastern Ohio in the mid-1990's found that, in terms of impact, there didn't appear to be a great deal of difference between employed and independent physicians.⁶² Job satisfaction was similar between employed and independent physicians, and so were the levels of satisfaction reported by their patients. The average visit was a little longer among employed physicians (11.5 minutes) than among independent physicians (9.1 minutes), and employed physicians provided slightly more screening and counseling services than independent physicians—but not as many immunizations. On the whole, therefore, the differences between the two groups seemed to balance each other out.

On the other hand, a study of 584 family physicians in Wisconsin, conducted by John Beasley, MD, and his colleagues in the year 2000, found that although independent and employed physicians were almost equally satisfied with their incomes (scoring 2.81 and 2.83 on a 5-point Likert scale, respectively), there were some real differences in outcomes between employed and independent physicians, with the independents generally reporting higher scores (Table 12). “Independent physicians reported better working relationships, more satisfaction with family time, more influence over management decisions, better satisfaction with being a physician, better perceived quality of the care they provided, greater ability to achieve professional goals, and lesser intention to leave the practice”—all this despite the fact that, on average, the independent physicians worked longer hours than the employed physicians (54.2 vs. 50.5 hours per week).⁶³

As the scores in Table 12 indicate, some of the greatest differences between the two groups involved internal practice dynamics, such as the quality of relationships within the work group and the perceived degree of influence over management decisions, with independent physicians reporting significantly higher scores on both items. But there are also modest positive differences in the scores for those items related to patient care, including continuity of care, ability to match time to the complexity of the patient, opportunity to fully use skills, and perceived quality of care, with independent physicians again reporting higher scores than the employed physicians.

Table 12

Comparison of Independent and Employed Wisconsin Family Physicians

Satisfaction with income	2.81	2.83
Amount of family time	2.33	2.19
Quality of relationships within work-group	3.30	1.01
Continuity of care	3.44	3.32
Often work under time pressure	3.04	3.06
Amount of paperwork is reasonable	1.10	1.30
Influence over management decisions	3.25	1.90
Ability to match time to patient complexity	2.62	2.44
Opportunity to fully use skills	3.36	3.16
Satisfaction with being a physician	3.48	3.26
Perceived quality of care	3.35	3.02
Ability to achieve professional goals	2.99	2.44
Intention to leave practice	1.68	2.31

Note: average scores based on 5-point Likert scale, except last item, which was based on a 7-point scale.

Source: Beasley, et. al.

Yet while the Wisconsin study found more favorable outcomes among independent physicians than among employed physicians, a study by James Reschovsky, et. al., drawing on national data from the 1996-97 Center for Studying Health System Change

Physician Survey, found that primary care physicians in medium-sized to large groups, in staff or group model HMO's, and in hospital-owned practices "were more likely to agree with the quality statements^{‡‡} than were those in solo or two-physician practices" (although those in medium-sized and large groups and group or staff model HMO's were less likely to agree that they had adequate time with their patients).⁶⁴

Along similar lines, a study published in the 2006 *Annals of Internal Medicine*, by Ateev Mehrotra, et. al., compared the quality of care received by California patients enrolled in PacifiCare who received their care from "integrated medical groups" (defined as "centralized organizations in which physicians are employees or participants in a partnership arrangement") with those who received their care from independent practice associations, and found that "patients cared for in IMG's generally received higher quality primary care than those cared for in IPA's."^{65 §§}

And in a recent April 2008 literature review for the Commonwealth Fund, Laura Tollen of the Kaiser-Permanente Institute for Health Policy identified several studies that reached similarly favorable conclusions regarding salaried physicians.⁶⁶ One found that "physicians in larger and salaried groups [were] more likely to engage in various quality improvement activities than solo-practice and non-salaried physicians."⁶⁷ Another found that "physician organization ownership by [a] hospital or health plan [was] significantly associated with greater use of care management processes," although the effect was "very small."⁶⁸ And a third found that "physician organization ownership by [a] hospital or health plan [was] significantly and positively associated with [an] increase in [the] number of health promotion programs offered."⁶⁹

Another way in which practice ownership may have an impact on quality is through its effect on physician satisfaction. A study by Bruce Landon, et. al. that appeared in the *Journal of the American Medical Association* in 2003 and that looked at data from the Center for Studying Health System Change Physician Survey from 1997 to 2001 found that "primary care physicians and specialists who became owners of their practices were more likely to report increased satisfaction," and noted that, according to prior research, "physician satisfaction is associated with quality of care, particularly as measured by patient satisfaction." The authors also pointed out that previous studies had found that "dissatisfied physicians are more likely to leave the profession and discourage others from entering."⁷⁰ In other words, this study, together with the earlier research cited by the authors, suggests that the positive impact of practice ownership on physician satisfaction may have a double-barreled positive impact on patients, both by improving the quality of care that they receive (as perceived by the patients themselves) and by increasing (or at any rate not reducing) the supply of physicians in active practice. Just how large these effects are, however, is not clear from this study.

^{‡‡} The survey asked respondents their level of agreement or disagreement with the following four quality statements: "It is possible to provide high-quality care to all my patients," "I have adequate time to spend with my patients during their office visits," "I have the freedom to make clinical decisions that meet my patients' needs," and "It is possible to maintain the kind of continuing relationships with patients over time that promote the delivery of high-quality care."

^{§§} Interestingly, the study also found that this difference was not attributable either to having an electronic medical record or to the utilization of explicit quality improvement strategies!

Most of these studies either did not look at a very broad range of quality measures or they did not focus specifically on independent practices, and many were based on self-report from physician respondents to a survey rather than on an objective independent assessment. Consequently, based on the published research currently available, it is difficult at this time to arrive at any definitive conclusions on the important question of what impact, if any, practice ownership has on the overall quality of care that patients receive.

Impact on patient trust

There are, however, some intriguing findings that suggest other ways, in addition to quality of care, in which practice ownership may make a difference to patients. One of those findings, reported in a 1998 article in the *Journal of the American Medical Association* by Audiey Kao, et. al., has to do with patient trust. Kao and his colleagues found that “more fee-for-service (FFS) indemnity patients (94%) completely or mostly trusted their physicians to ‘put their health and well-being above keeping down the health plan’s costs’ than salary (77%), capitated (83%), or FFS managed care patients (85%).”⁷¹

Although the study focused on payment rather than ownership, the fact that salaried physicians were trusted by the smallest proportion of patient respondents suggests that practice ownership does indeed matter to patients. As one of the physicians we spoke with put it, “There’s no question that there’s an agency issue here. Independent doctors are not subject to the kinds of organizational pressures that salaried doctors are.”

Impact on charity care

Yet another way in which practice ownership appears to have an impact on patients has to do with the provision of charity care to the growing number of Americans who are uninsured or seriously underinsured.

In their analysis of data from the Center for Studying Health System Change Physician Surveys between 1996-97 and 2004-05, Peter Cunningham and Jessica May found that while the proportion of actively practicing physicians providing charity care has fallen from 76% to 68%, the decline has been greater among employed physicians than among independent physicians.⁷² Moreover, the likelihood of providing charity care has been and remains a good deal higher among independent physicians and those in solo and small group practice than among those who are employed and those who practice in large group or institutional settings (Table 13).

Table 13

Percentage of Actively Practicing Physicians Providing Charity Care,
By Practice Ownership and Practice Size, 1996-97 to 2004-05

	1996-97	2004-05
Full or part owner	83.0	78.2
Non-owner	65.6	56.4
Solo/2-physician practice	83.9	81.8
3-10 physician practice	81.2	78.5
11-50 physician practice	76.5	66.2
50+ physician practice	73.3	61.9
Group/staff HMO	45.1	35.8
Medical school	74.1	54.6
Hospital	66.3	54.5

Source: Center for Studying Health System Change

As Cunningham and May point out, “Physicians in larger groups and institutional-based practices (ie., medical schools or hospitals) are much less likely to provide charity care [than physicians in solo or small group practice], and charity care among these physicians declined sharply between 1996-97 and 2004-05. Furthermore, a decreasing number of physicians are in solo practice, and an increasing number of physicians are practicing in practice settings that are less likely to provide charity care... Similarly, physicians who own their own practice are more likely to provide charity care than non-owners (who are more likely to be in large practices and institutional settings). While charity care decreased between 1996-97 and 2004-05 for both owners and non-owners, the percentage of physicians who are full or part owners has been steadily decreasing, from about 62 percent in 1996-97 to 54 percent in 2004-05.”⁷³

So there are three things going on here: (1) independent physicians are still more likely to provide charity care than employed physicians; but (2) the proportion of physicians in independent practice has been declining while the proportion who are employed has been going up; and, at the same time, (3) the likelihood of providing charity care has been falling more rapidly among employed physicians than among independent physicians. The upshot of these developments is that decline in the proportion of physicians in independent and/or small practices appears to be *exacerbating* what is already an across-the-board reduction in charity care among all physicians (which, according to

Cunningham and May, is probably attributable to the growing economic and time pressures on practicing physicians in all settings).

What makes this decline in charity care among physicians especially significant is the fact that, despite the important roles that community health centers, public hospitals and hospital emergency rooms play in providing charity care, private physicians are in fact the mainstay of the nation's health care safety net for poor and uninsured patients. As we reported in *Health Affairs* in 2007, “more than one in four Americans—roughly eighty-eight million people—either are uninsured or receive Medicaid coverage... [and] roughly four out of five patients who are uninsured or Medicaid recipients receive their primary care in a physician's office.”⁷⁴

And while it is possible that under the Obama administration there will be reductions in the number of uninsured, the history of past health care reform efforts (including California's recent effort to achieve universal coverage, which failed despite the support of a popular Republican governor and both leaders of the Democratic legislature⁷⁵) suggests that it is unlikely that the need for charity care will be completely eliminated any time soon.

A caveat

While the studies we reviewed suggest that there may be a variety of ways in which practice ownership affects both patients and physicians themselves, the literature on this important question is in fact rather thin. As we pointed out, the findings with respect to quality are piecemeal and mixed—and therefore not definitive. And the number of studies exploring the impact of practice ownership on such critical issues as patient trust, rural access, and charity care are slim to none.

Given the substantial decline in independent practice that has occurred over the past several decades, and given that many people (including most of the Foundation's Board members whom we interviewed) expect this decline to continue—especially among small primary care practices—the fact that not much is known about what impact this decline may have on patients and on the nation's health care system is, we believe, a cause for concern. As a nation, we are almost, but not quite, flying blind.

CONCLUSION

In this report, we have sought to provide an overview of independent medical practice in the United States. Our review of the existing research literature, together with our interviews with thoughtful observers in the field, makes it clear that while some independent physicians are still thriving—particularly procedure-based specialists in single-specialty groups—many of the nation's small independent practices are struggling, caught between falling revenues and rising costs and with no real leverage to negotiate a

better deal for themselves. What's more, most of the observers we interviewed were not at all optimistic that the outlook for these practices was likely to improve in the coming years, short of dramatic changes in current reimbursement policies.

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