

Ambulatory services

To the extent that anyone "controls" the health care system, it is the physician. Because of prestige and political power, the physician has escaped most direct regulation and has preserved a good measure of freedom to organize and conduct a practice as he or she sees fit. There is, however, no freedom from pressures of the market for health services. Today the physician faces considerable pressure both from expanding numbers of colleagues and from inflation. How the physician adapts to these market pressures will have a major bearing on the future organization of his or her services, and on the future of the hospital as well. In this chapter, we explore the diversification of the ambulatory services sector which the physician controls and the implication of economic competition on the structure of a practice.

MEDICAL PRACTICE-THE LAST FRONTIER

The practicing physician is one of the last surviving independent entrepreneurs on the American scene. Even more than other professionals, physicians seem to be infused with a powerful spirit of "don't tread on me." As we will discuss below, while the number of physicians in group practice is growing, over 60 percent of the 239,000 physicians in private office practice as late as 1976 were solo practitioners.¹ As a physician writing in the late 1960s put it:

It was a need for freedom that made me choose solo practice ... solo decision-making is at the heart of good medical practice and . . . a doctor's freedom to decide is to some extent compromised when he becomes part of an organization.²

Since physicians are entrusted with the management of people's health and can be held both legally and morally responsible for the loss of life, there are powerful reasons why physicians want to control as many as possible of the factors which govern whether they succeed. Professionals in general, but physicians in particular, are perfectionists and become accustomed to the unquestioned exercise of authority in their practice.

This exercise of power has economic consequences. An estimated 71 percent of the nonfederal physicians engaged in patient care in the United States are compensated through the fee-for-service system,³ a hallmark of independent physician practice. The combination of largely unchallenged freedom to direct the practice of medicine with the piecework method of compensation has attracted severe criticism from some economists. This criticism has given rise to an image of the physician as "economic man" who abuses professional power to increase income by prescribing medically unnecessary treatment for patients.

Some of these critics have extended the argument to its logical conclusion—that physicians will generate enough demand for their services to permit them to reach a hypothetical "target income."⁴ If competition from other physicians (e.g., in areas of high physician density) reduces the volume of patient visits, physicians will simply increase their fees to produce the same income level. Uwe Reinhardt, one of the most sophisticated (and wittiest) of these critics, believes that since each new physician will necessarily generate between \$250,000 and \$500,000 in healthcare expenditures each year, restricting physician supply and compelling them to increase their productivity is the most effective way to restrain health care costs over the long run.

The debate over the merits of reimbursing physicians by methods other than fee-for-service, such as the capitation methods used by health maintenance organizations (HMOs), is likely to continue for some time. But the caricature of the physician as an omnipotent income maximizer fails on at least two counts. First, it fails to take into account the intense professional pride which most physicians bring to their practice and the nature of the satisfactions they derive from it. Frank Sloan, a perceptive observer of physician practice, has commented that neoclassical theory provides only the most general guide.

It was not designed to explain the behavior of trained professionals seeking more out of work than financial security at minimal levels of effort.⁵

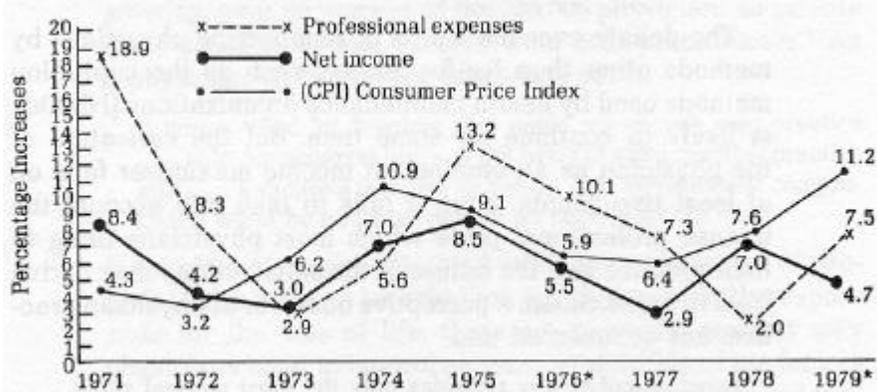
Furthermore, the caricature bears only minimal relationship to what most of us know of our own physicians and their colleagues. Besides being vicious and demeaning, however, it does not reflect accurately the economic realities.

Economist critics argue that physicians have sufficient control over utilization to generate revenues so that they can set their income levels at will. If this is so, this theory does not account

for certain recent developments in physicians' income and activity. One could reasonably assume that physicians would have used that power to hold themselves harmless from the recent inflationary surge. The facts do not bear out this contention.

Two surveys of physician income trends established that physician net incomes declined during the 1970s on the average. In 1979, analysis of the American Medical Association's annual survey of its membership established that, during the 10 years 1970 through 1979, gains in physician net incomes (pretax) fell considerably short of keeping up with inflation. During this period physician practice costs increased at an annual percentage rate of 8.3 percent, while gross professional income, which reflects fee levels charged for physician services, increased by only 6.7 percent. Physician net incomes increased at an annual average of 5.7 percent, compared to an annual rate of increase in consumer prices of 7.2 percent. According to the AMA data, the slippage accelerated in the last three years of the decade. In 1979, consumer prices increased by 11.3 percent while physician net income grew by 4.7 percent.⁶

FIGURE 2-1
Annual percentage increase in physicians' average professional net incomes and average professional expenses, 1971-1979



* = Expense and Income data for 1976 and 1979 projected by physician respondents.

Source: Periodic Survey of Physicians, 1972 – 1979, Center for Health Services Research and Development (Chicago: American Medical Association). Consumer price index data from *Handbook of Labor Statistics, 1978* (Washington, D.C.: Bureau of Labor Statistics, U.S. Department of Labor) for 1971-77 Data; For 1978-79 Data, telephone conversation with Bureau of Labor Statistics, July 1, 1980.

As can be seen from Figure 2-1, physicians net income lost ground to inflation in every year after 1972. While data are not available to explain precisely why practice costs rose so sharply in 1971 and in the 1975-77 periods, one can speculate that they reflect sharp, non-incremental increases in the cost of malpractice insurance, and labor cost catch-up following two periods of high inflation. It is strongly suspected that the brunt of this cost and income pressure has been borne by the new entrants into the physician marketplace, and that these averages mask sharp gradations of activity and income between generations of physicians.

In a survey of physicians conducted by *Medical Economics* for the five-year period from 1975 through 1979, a similar finding was established. For all specialties, the five-year loss in the purchasing power of net income was 4 percent, comparing 1979 median incomes to 1974 dollar value. Of the various specialty groups, only orthopedic surgeons and internists were able to stay ahead of inflation. By contrast, pediatricians lost about 9 percent, general surgeons about 10 percent, and obstetricians and gynecologists almost 12 percent. Furthermore, only 43 percent of the physicians surveyed expected their practice earnings in 1980 to be higher than in 1979, while 13 percent actually expected them to be lower (in actual, rather than constant, dollars).⁷

Several things must be said to put these findings in perspective. No data was gathered by either survey on trends in physician *net worth*, which may have increased more rapidly than inflation, particularly as "bracket creep" and changes in the tax laws encouraged physicians to shelter more of their income. Also, it must be noted that even given the diminution of purchasing power, average physician salaries are still substantially higher than for most of the rest of us. The AMA average net income for all specialties was \$68,999 in 1979,⁸ while the *Medical Economics* average net income was \$76,720.⁹ Physicians continue to be our wealthiest occupational group by a wide margin. But they are not immune to the economic realities of inflation. Their economic powers, while considerable, have not enabled them to escape inflation's pressures.

Even more significant, however, is evidence of declining physician activity levels. Data on the median number of visits per physician week, showed a decline of 13 percent from 1974 to 1980 for all specialty groups. Some specialty groups showed even steeper declines over longer periods

of time. General practitioners surveyed showed an approximate decline of 22 percent from 1972 to 1980 in median weekly visits, while general surgeons showed a 21 percent decline over 10 years.¹⁰ Independent confirmation of this trend is available from federal health survey data, which showed a nearly 4 percent decline in the number of reported physician visits between 1975 to 1978. The per capita visit rate for persons of both sexes dropped from 5.1 to 4.8 visits during the same period.¹¹ Many physicians appear to be working at less than full capacity and not necessarily by choice.

Several factors may be at work in producing income and activity trends. Economic conditions may have reduced discretionary consumption of physician services. They may also have prevented physicians from collecting income from increasingly hard-pressed patients even though they continue to increase their fees. It is suspected that patients may be less willing to pay physician fees than other expenses because they perceive that the physician is wealthy and can afford to lose the income. Professional fee receivables undoubtedly contributed to the growing gap between gross billings and net income. Unfortunately, data to substantiate this suspicion are not readily available.

But other factors of greater long-term significance may be at work on the physician supply side. The growing number of medical practitioners may have begun to affect physician professional activity and incomes. During the period of the AMA survey, the number of physicians in the United States increased by over 30 percent. The outlook for physician supply suggests that competitive pressures will increase rather than diminish in the future. These pressures will reshape the practice of medicine, creating both challenges and opportunities for physicians.

OUTLOOK FOR PHYSICIAN SUPPLY

In 1976, David Mathews, secretary of what was then the Department of Health, Education, and Welfare, created a body called the Graduate Medical Education National Advisory Committee (GMENAC) to advise him on the nation's future health manpower needs, and on the appropriate federal policies for meeting those needs. This study, the most comprehensive analysis of medical manpower yet conducted, not only mapped past growth in the number of physicians in various specialty areas but, using a sophisticated model of demographic, epidemiological, scientific and technological trends, projected needs in the various medical specialties for the year 1990.

The final report of this body estimated that by 1990 the nation will have approximately 536,000 physicians, 33 per cent more than in 1978 and 79 percent more than in 1970. This total represents approximately 70,000 more than the GMENAC study estimated will be needed in 1990. The projected surplus will double to 145,000 during the following ten years.¹² The goodness of fit between projected supply and projected needs varies considerably according to specialty, with persistent shortages predicted in psychiatry, emergency medicine, and preventative medicine. Some surgical and medical sub-specialties such as neurosurgery, endocrinology, and pulmonary medicine are projected to produce nearly double the number of specialists needed by the year 1990. Tables showing these projections are in the Appendix.

The report also predicts little progress in resolving the serious geographical maldistribution of physicians. For example, New York State has nearly two and a half times as many practicing physicians per 100,000 people as Alabama. Statewide physician-to-population ratio data may also be found in the Appendix. These data mask substantial disparities within states between suburban and inner city areas. For example, the large inner city area surrounding the University of Chicago had only 773 physicians in practice for a population of almost 1.2 million during 1976, a ratio of physician-to-population coverage reflecting only about half of the statewide average for Illinois.

Physicians prefer to practice in areas where it is desirable to live, where cultural and recreational opportunities exist commensurate with their income expectation. This predisposition is strengthened by the reimbursement policies for the Medicaid program, which is the dominant payer for physician services in many inner city and less prosperous rural areas. In Illinois, for example, the Medicaid reimbursement rate for a basic physician's office visit in 1980 was \$10.50, much less than half the prevailing level of charges in the area. These reimbursement policies have aggravated physician supply problems in areas where there are large numbers of poor people.

Perhaps unwittingly, Congress worsened the supply outlook for many inner city and rural areas in 1976 when, in response to organized medical pressure, it tightened restrictions on the entry into the United States of foreign-trained physicians. The GMENAC report recommended further

restriction of so-called foreign medical graduate (FMG) entry into the United States as one step toward reducing the impending surplus of physicians. Municipal hospitals, which deliver large amounts of care to the inner city poor, as well as state mental hospitals and hospitals in some rural and depressed suburban areas, are differentially dependent on FMGs, who frequently fill gaps created by practice preferences of American trained physicians.

How these patterns of geographical distribution change in response to further growth in physician supply remains to be seen. There is some evidence from a recent Rand Corporation study that medical specialists are moving into rural areas and small towns in increasing numbers.¹³ It is reasonable to speculate that physician density in highly desirable areas (southern California, for example) will continue to increase until the market signals to potential newcomers that it is saturated. Research on the behavior of local or regional physicians markets in these areas should be conducted, both because little is known about them and because these market conditions presage conditions in the rest of the country.

Increasing competition between physicians seems likely to continue to retard the growth in physician net incomes and compel physicians to re-examine the structure within which they practice. New entrants into the physician market, and there are now more than 17,000 of them annually, will be compelled by competitive conditions to develop new and more effective methods of delivering primary physician services. These pressures are likely to produce structural changes in the physician-controlled sphere of ambulatory care as profound as those taking place within the hospital industry.

STRUCTURAL CHANGE IN AMBULATORY PRACTICE

In economic terms, a physician's practice is a small business. For solo practitioners, such enterprises may gross as little as \$50,000 to \$100,000 a year, while large group practices might gross as much as several million annually. These solo and group practices accounted for most of the \$40 billion in direct physician economic activity in 1979 and, indirectly, for a significant portion of the \$85 billion in hospital expenditures in the country during the same period.¹⁴ While there has been some growth in new forms of physician practice in recent years and increased interdependence among physicians due to increasing specialization, the modal unit of production of physicians services has changed little in the last hundred years. Some of the reasons for this were discussed above and include the physician's desire to control his or her own destiny. However, market forces may create financial trade-offs for this "freedom" which new entrants into the physician market may be either unwilling or unable to make. Some of the likely changes in the structure of physician practice are discussed below.

INCORPORATION

For many years, organized medicine has opposed the "corporate" practice of medicine.* Many states enacted statutes to forbid lay control over medical practice, on the grounds that it would compromise the quality of patient care. As medical practice has emerged as a major economic force, attitudes toward the physician's role in corporate organization has moderated somewhat. By 1980 virtually every state has a professional incorporation statute which permits some form of corporate structure for professional medical practice, mandating explicit physician control over the corporation. Though the percentage of physicians who participate in incorporated practices rose sharply during the 1970s, only about half of practicing physicians in the United States participated in incorporated medical practices as of mid-1979.¹⁵ The tax and other advantages to incorporation yield much greater returns to physician income than unincorporated practice does. In 1979 incorporated physicians grossed 64 percent more than their unincorporated colleagues and netted 42 percent more. The spread for solo practitioners was even more dramatic, with incorporated solo practitioners grossing 72 percent more than solo unincorporated practitioners and netting 48 percent more.¹⁶ ** These data are somewhat misleading since the ability to incorporate is conditioned upon generating sufficient after-tax income to be able to support the physician's financial obligations and lifestyle.

* A 1949 Report to the American Medical Association House of Delegates most clearly enunciated this policy: ". . . it is illegal . . . and unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce a profit for a lay employer, either individual or institutional (hospitals and medical schools)."

** The net figures for incorporated physicians represent pre-income tax earnings including bonuses and tax deductible retirement contributions.

The true advantages to incorporated practice lie in the tax sheltering of retirement benefits and the fringe benefit advantages of incorporation. Most self-employed individuals are permitted to invest \$7,500 or 15 percent of their gross income, whichever is less, in Keogh retirement plans and reduce their taxable income by such investments. Under incorporation, physicians are able to deduct substantially larger percentages of their income for participation in corporate profit sharing and pension programs. The resulting takedown of gross income produces tax advantages many times larger than Keogh plan provisions.

In addition, incorporation permits physicians to deduct personal health and, in group settings, group life insurance premiums as a corporate expense, eliminating the need to pay for these essential fringe benefits with expensive after tax dollars. Under certain circumstances, physicians may even loan themselves funds from their own retirement assets set aside. These tax provisions permit the incorporated physician to shelter large amounts of current income from taxes and to build large equity bases not permitted the unincorporated colleague.

There are two chief reasons why physicians do not incorporate. First, they may not be taking home enough income to be able to afford to take advantage of the tax benefits of incorporation (e.g., to make the retirement plan contributions). Second, incorporation requires time, legal assistance, paperwork, and additional record-keeping that some physicians are simply not willing to invest. They may also involve sharing benefit plans with employees, which is an expensive proposition. It seems clear, however, that additional financial pressures may compel more physicians to modernize the organizational setting within which they practice. It is strongly suspected that the proportion of physicians practicing in incorporated settings will continue to grow.

GROUP PRACTICE

For years, medical economists have inveighed against physician resistance to practicing in groups, arguing that the sharing of facilities and support costs and the continuity of physician relationships benefited the patient both economically and medically. As few as fifteen years ago only 11 percent of the physicians in practice in the United States practiced in groups.¹⁷ In 1980 an AMA study established that approximately 88,000 physicians practice in groups, more than double the number in 1969. However, despite this growth, only about 26 percent of practicing physicians are part of groups.¹⁸ * Though the attitude toward group practice among recent or impending graduates of medical school may be moderating, the long-standing professional attitude toward group practice has been unremittingly hostile.

The first public expression of organized medical sentiment toward group practice was a 1920 policy statement on the possible infractions of ethical standards which might be inherent in group practice.¹⁹ In 1927, when the University of Chicago opened its Hospitals and Clinics, the salaried group practice organization of its medical faculty provoked angry reaction from the Chicago medical community. The university's staffing plans were regarded as the "corporate practice of medicine" by practitioners in the community. In response to this reaction, the university was compelled to conclude an agreement with the Chicago Medical Society to see only as many patients as were absolutely essential for teaching and research purposes and not to charge professional fees for the services of its faculty.

Though economists such as Reinhardt have advocated consolidation of solo physician practices into large-scale groups, recent research has undercut the claim that large group practices produce significant economies. A number of these studies, reported by Richard Ernst, found that "the optimal or most productive scale of practice occurs at the small-group level."²⁰ Frank A. Sloan put the most efficient scale of group practice at about six physicians, quite far indeed from the large "medical corporations" envisioned by some critics.²¹

* The American Medical Association Council on Medical Services defines group practice as "the application of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis and/or treatment through the joint use of equipment and personnel, and with income from medical practice distributed in accordance with methods previously determined by members of this group." Two-person practice is usually termed *partnership*.

The income advantages to group practice for the physician appear to correlate with group size as well. According to AMA survey data for 1977, physician net income was highest among physicians who practiced in five- to seven-person groups, and the next highest for those practicing in three-person groups. The average net income for solo practitioners was 6.4 percent below the average for all physicians and 21 percent below that of the physicians in five- to seven-person groups.²² Thus, while there is evidence that physicians in solo practice sacrifice considerable net income for the autonomy which solo practice provides, there is little evidence that large scale groups serve the physician's economic interests much more effectively.

While there appear to be some income advantages to physicians in group practices, it is not clear that these advantages are produced by the return on physicians' services alone. Some theorists have suggested that group practice is a vertically integrated form of "production" with two outputs—physicians' services and ancillary (laboratory and radiology) services.²³ The returns from the physician component of practice alone are not impressive, and according to R. M. Bailey actually decrease slightly as the group grows larger.²⁴

However, those specialists (internists, general practitioners, orthopedic surgeons), which are heavily dependent on ancillary services such as X-ray and clinical laboratories, can generate significant fractions of their total practice income from ancillary services and capture an increasing amount of the economic rewards for their practice. Ancillary services are highly profitable in an office setting, because work is usually done by relatively low-paid technicians and the physicians themselves interpret the results rather than using expensive radiologists or pathologists. There are financial incentives for many practitioners to integrate ancillary production into the group setting. Ancillary profits are a significant incentive for the formation of groups, one which is likely to become more powerful as market pressures reduce the profitability of the physicians' services component of what a practice produces.

Thus just as we will see later in the case of hospitals, market pressures in the physician sector appear to create incentives to develop incorporated, vertically integrated structures for delivery of physician care. In their respective efforts to maximize physician income and market position, however, physicians and hospitals may be on a collision course. That is, as physicians develop more sophisticated forms of corporate organization, and begin to deliver (and hence control) a wider range of medical services, physicians will be increasing competitive threats to the hospitals in which they practice.

NEW FORMS OF AMBULATORY CARE

A principal thesis of this book is that economic pressures and market opportunities will compel physicians to offer a fuller range of medical services in settings they control. A variety of new forms of delivery of health care by physicians, as well as more sophisticated structures like vertically integrated group practice, present hospital managers with the possibility of significant losses of admissions, patient days, and (profitable) ancillary services volume. How hospital managers cope with this long standing but increasing competitive pressure may determine the long-run viability of their organizations.

Hospital diagnostic activity

A significant percentage of the inpatient admissions to the hospital are for diagnostic work-ups. Until comparatively recently, hospitals have offered the only convenient setting for the conduct of diagnostic tests, principally because of hospitals' near monopoly on diagnostic technology and because the logistics of working up a patient outside the hospital were too complex and inconvenient for the patient. With the growth of multi-specialty practice, and the development of the hospital-independent ancillary services in these groups and in physicians' office buildings, this balance of technology and convenience may be changing. Furthermore, income sharing arrangements which permit the patient's primary physician to capture some of the financial return from those services which accrue to a hospital-based practitioner if the patient is admitted to the hospital, may create financial incentives to work the patient up outside the hospital.

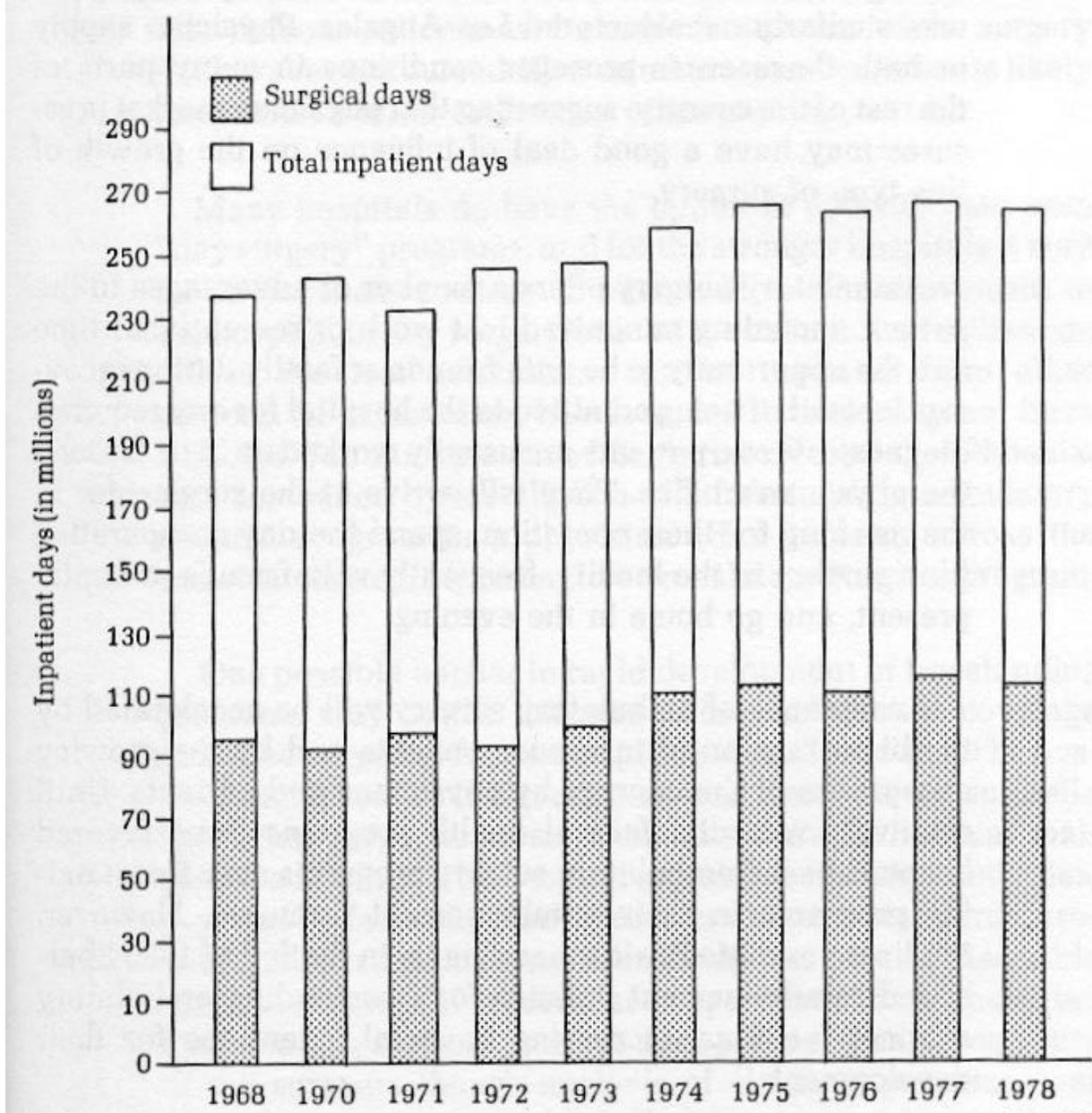
In a Massachusetts study of hospital utilization patterns, Odin Anderson found that approximately 14 percent of hospital admissions in a large sample were for diagnostic purposes. When he probed the extent of physician discretion in these admissions, he found that only 45 percent of the procedures which necessitated admission were "impossible except in the hospital." Another 32 percent were considered "extremely difficult except in the hospital." Thus, almost one quarter of the admissions were "discretionary" in the sense that it was either possible or equally

convenient to perform them outside the hospital. With advances in medical technology and in the concentration of medical practices over the last 20 years, it is strongly suspected that this percentage has increased. The combination of increasing extra-hospital logistical capability and economic incentives may significantly reduce the primary physician's rate of diagnostic admissions to hospitals in the future. The loss of hospital ancillary activity may, in turn, undermine the economic viability of the hospital by shrinking ancillary profits which are used, through cross-subsidization, to support such unprofitable activities as hospital-based ambulatory care.

Ambulatory surgery

Probably the most significant potential impact of the physician's increasing economic independence from the hospital is on a hospital's surgical utilization. Surgical utilization is the core of a hospital's inpatient volume. As can be seen from Figure 2-2, surgical utilization represented approximately 43 percent of the total community hospital inpatient days in 1978. From 1970-78, growth in inpatient surgical utilization accounted for 87 percent of the increase in hospital inpatient days.

FIGURE 2-2
Total inpatient days and surgical days: short stay and specialty hospitals, 1968-1978



Source: Data obtained from National Center for Health Statistics, U.S. Department of Health and Human Services; and total inpatient data from American Hospital Association, *Hospital Statistics*, (Chicago, 1980).

In light of this important role of surgery in overall hospital utilization, the growth of freestanding ambulatory surgical (or "day surgery") programs poses a significant threat to hospital surgical programs. As much as 40 percent of all surgical procedures can be performed on an outpatient basis,²⁵ without either pre- or postoperative hospitalization. These procedures are concentrated in such "primary care" surgical specialties as otolaryngology, urology, and ophthalmology, as well as some more inpatient oriented specialties such as plastic surgery. The result may be a savings (to the patient and insurer) and loss (to the hospital) of from one to three days of hospitalization per procedure.

Though national data on the prevalence of ambulatory surgery is not available as of this writing, data has been obtained on one very active market-Phoenix, Arizona, with a metropolitan population exceeding 1.5 million. According to data assembled by the Central Arizona Health Systems Agency, nearly 28 percent of all surgical procedures performed in the region in 1979 were done on an ambulatory basis.²⁶ More than one third of the ambulatory surgical procedures were done in freestanding facilities. The Central Arizona HSA set an objective of having 40 percent of all surgery done on an outpatient basis by 1984, which appears to be an ambitious objective given past growth rates. Phoenix was among the first markets to embrace ambulatory surgery, as was similarly over-doctored Los Angeles. Physician supply in both these areas presages conditions in many parts of the rest of the country, suggesting that physician market pressures may have a good deal of influence on the growth of this type of surgery.

Ambulatory surgery offers a number of advantages to the patient, including minimized lost work or recreational time and the opportunity to be with friends or family during recovery. Instead of being admitted to the hospital for any required diagnostic work, patients are usually worked up in or through the physician's office. They will arrive at the surgicenter in the morning for their operation, spend the day recuperating from surgery in the facility, frequently with friends or family present, and go home in the evening.

Acceptance of ambulatory surgery will be accelerated by the liberalization of insurance benefits and by the growing acceptance of the concept by physicians and patients. Until relatively recently, federal health programs have favored hospital-based ambulatory surgery programs over freestanding programs in their reimbursement formulae. However, Medicare and Medicaid amendments in the fall of 1980 liberalized reimbursement policies for freestanding ambulatory surgical facilities, increasing financial incentives for their development.

Growth in ambulatory surgery may also be accelerated by the increasing reluctance of insurers to reimburse hospitals for inpatient stays associated with surgical procedures which can be performed on an outpatient basis (unless evidence is presented of complicating factors which require patient monitoring or full-scale inpatient surgery). Such developments will not necessarily damage the practice incomes of surgeons who have access to ambulatory surgical facilities (either hospital based or freestanding), but they could impede access to surgical services for those patients whose physicians do not have such access. The California Medicaid program (MediCal) will reimburse for many inpatient surgical procedures only if the physician documents either the lack of outpatient facilities for such surgery or the medical necessity of inpatient care associated with it. This demonstration must be made in advance of the surgery if it is to be reimbursed. This reimbursement practice is likely to spread to other states and other payers.

Many hospitals do have the option to develop their own "day surgery" programs, and for the stronger hospitals it may be an excellent strategy to pursue. However, movement in the hospital to day surgery can reduce its inpatient utilization unless the lost admissions can be replaced from other sources. In some cases, however, institutions may not have a choice. For example, Good Samaritan Hospital of Phoenix, was compelled by installation of a freestanding ambulatory surgical program in a physician office building across the street to create its own captive ambulatory surgical program.

One possible barrier to rapid development of freestanding programs may be the thinness of the malpractice coverage provided surgeons for nonhospital surgical practice. The hospital's malpractice insurance provides a convenient umbrella sheltering surgeons from potentially ruinous medical malpractice liability. The hospital's quality-assurance activities, required by federally mandated accreditation standards, provide malpractice insurers a rationale for more reasonable surgical coverage if procedures are performed in the hospital. Freestanding surgical practice does present greater exposure to the surgeon, though analysis of claims experience over several years may establish that the types of procedures performed on an ambulatory basis do not result in greater risk. This may, in turn, result in a softening of malpractice rates for freestanding surgical practice.

Hospital managers have reason to be concerned about the impact of freestanding ambulatory surgery on their operations, since surgery is another major profit center in most hospitals. The ability of hospital medical staffs to separate a significant portion of their surgical activity from the hospital poses a major threat to its overall inpatient activity. Hospitals which develop their own programs need not lose "facility" charges or ancillary volume but may be faced with empty beds.

Like the freestanding emergency facilities discussed below, freestanding ambulatory surgical facilities are eminently adaptable to franchise operation. Facilities plans, staffing, and financial systems are all amenable to standardization. It is not unreasonable to speculate that some of the corporate organizations moving swiftly into the health care market could develop "turn key" ambulatory surgical facilities which could be constructed and put quickly into operation in regional or national markets. Hospital management firms are more likely to build such programs into their base hospitals than to put up freestanding facilities, though the potential for damaging *competing* hospitals' surgical volume through strategically placed freestanding facilities may not be lost on some of these firms as local market conditions tighten. The key constraint on franchise expansion may be recruitment and retention of quality physicians to staff them.

Urgent care centers-freestanding emergency facilities

Hospital emergency rooms are major contributors to inpatient utilization of the hospital. From 15 to 30 percent of all hospital admissions may come through the emergency room. In many urban areas emergency rooms have become the beneficiaries of many visits from patients who are not acutely ill but who have no physician or other means of getting care. Thus in many underserved areas 60 percent or more of the visits to the emergency room may be nonemergency cases. So not only is the emergency room an important source of inpatient admissions; it has become the health care system's current answer to the patient's need for episodic, nonscheduled health care.

Both for reasons of high cost and the "softness" of ER patient volume diagnostically, hospital emergency rooms are vulnerable to substitution of innovative methods of delivering episodic care. Such an innovation appeared on the horizon in the middle 1970s in the form of the urgent care center, or freestanding emergency facility. According to a study conducted for the Robert Wood Johnson Foundation, there were approximately 55 in existence in the United States in late 1978.²⁷ It is believed that many times that number are now in operation, though reliable estimates are not available.

These facilities can provide most of the services of a hospital-based emergency room except for full scale surgery (since they lack the capability of administering general anesthesia). However, they are capable of performing minor surgery, setting broken bones and applying casts, or stabilizing a stroke patient, as well as dealing with nonacute medical problems. Most facilities have their own laboratory and radiology facilities, though some contract these services out if rapid turnaround on tests at a reasonable cost is available nearby.

A network of such facilities has been developed in the Chicago area by a former health partner of Arthur Young and Company, Dr. Bruce Flashner. The name of the facilities, Doctors Emergency Officenter, cogently expresses the hybrid nature of the service. They operate 16 hours a day on a no-appointment basis. The first three facilities reached the break-even level of patient visits within six months of their opening, in different northwest suburban Chicago locations.

Dr. Flashner experienced hostility from anxious physicians practicing near his facilities until it became clear that he did not intend to build an on-going practice through the centers. Patients are returned to their family physicians for continuing care or referred to specialists needed for complex conditions. In addition to a single physician per shift, a center employs three allied health personnel per shift who are crosstrained to handle billing, laboratory and radiology work, as well as to handle problems in patient flow through the facility. Dr. Flashner was able to avoid capital outlays in two of his facilities by leasing both facility and equipment. The capital costs of the leases were less than \$100,000 per facility.

The facility is a cross between a private physician's office and an emergency room. It is a competitive threat to both. Such facilities bridge the gap between the frequently impersonal emergency room, where the patient may endure a lengthy wait, and the private physician's office, where the patient may wait days or weeks for an appointment. Competition from urgent care centers may force private physicians to allocate some appointment time to accommodate walk-in visits by their patients and to make afternoon and evening service available which is more convenient to patients with inflexible work schedules or other commitments.

Urgent care centers are a threat to hospitals because they deprive the hospital of control over the decision to admit a patient from the emergency room. Physicians in freestanding facilities have absolutely no incentive to hospitalize a patient, while the triage threshold which admits a patient through a hospital-based emergency room may move up or down depending on the hospital's

occupancy rate. Though no research has been done on the question, it is reasonable to speculate that the ratio of outpatient visits per inpatient admission may be much higher in a freestanding facility than in a hospital-based emergency room.

Nevertheless, hospitals anxious to increase their occupancy may offer physicians in urgent care centers preferential admitting privileges for patients referred for hospitalization. Because many hospitals rely on physician on-call lists to provide coverage for patients admitted through hospital emergency rooms, preferential access to referrals from freestanding facilities may mean, in practice, that a patient admitted through a freestanding facility can get admitted to the hospital more quickly than if he or she were admitted through the hospital's own emergency room.

As with ambulatory surgical programs, hospitals do have the option of developing satellite urgent care centers, which gives them control over patient flow even though emergency care is delivered offsite. An example of this strategy is the establishment of a captive freestanding emergency facility in the far eastern suburbs of Phoenix by the Samaritan Health Service. The facility feeds the easternmost network hospital in the Samaritan system for those emergency cases requiring hospitalization. It was established in a rapidly growing area to provide Samaritan a medical presence that could form the nucleus of another hospital if population growth continues at the current pace. Captive facilities provide hospitals control over the geographic origins of their patients and a relatively low cost method of entering new or developing markets.

Freestanding dialysis centers

Kidney dialysis originated as an extremely costly procedure for treating kidney failure that could be conducted only in an inpatient hospital setting. With expanded government funding for treatment of end-stage renal disease provided under Medicare in 1972, and as a result of significant technological advances, most dialysis can now be performed on an outpatient basis.

As dialysis became available to more individuals needing it, outpatient dialysis services developed in freestanding settings. About 280 freestanding proprietary and nonprofit facilities treated about 47 percent of all dialysis patients in 1979. A single, investor-owned firm, National Medical Care, operates 40 percent of these facilities.²⁸ Hospital-based outpatient dialysis programs compete with freestanding proprietary and nonprofit organizations for dialysis patients. Hospitals are at a competitive disadvantage because the Medicare cost allocation principles allocate full hospital overheads to outpatient dialysis treatment, making it much more expensive than care in freestanding units. The number of hospital-based dialysis programs dropped 7 percent, from 680 facilities in 1977 to 635 in 1979.

Competition is likely to increase as a result of federal regulations promulgated in late 1980 which subjected hospital-based outpatient dialysis rates to a prospective payment system, which may cause deficits in many hospital-based programs and encourage them to close. The Reagan administration's apparent intention to abolish the higher hospital-based outpatient dialysis reimbursement rate in favor of a consolidated single rate for hospital-based and freestanding centers may spell the end of hospital-based chronic dialysis programs.

Freestanding dialysis centers can affect a particular, highly specialized market for inpatient hospital services in an important way. Specifically, there are powerful economic incentives for freestanding dialysis centers not to refer patients to tertiary hospitals for kidney transplants. The obvious reason is that a successful transplant obviates the need for further dialysis, removing the referred patient from the orbit of the freestanding agency. Thus the growth and potential dominance of the freestanding facilities in the dialysis market could help dry up demand for transplant surgery, further affecting a hospital's surgical volume in another profitable area.

THE PHYSICIAN AND THE HOSPITAL

All the developments discussed above have a common consequence. By developing new forms of ambulatory care, many of which offset or reduce the need for hospital inpatient care, physicians represent an increasing economic threat to the hospitals at which they practice. The incentives to develop new corporate structures and new forms of ambulatory care, under physician control, will increase as economic pressures from physician competition encourage physicians to capture more of the financial rewards of patient care and share less of them with the hospital. Since the decision to hospitalize a patient rests with the physician, the economic balance of power between the physician and the hospital manager, always a sensitive one, is likely to tip in the direction of physicians (even given their increased numbers). And as

hospital costs continue to escalate, insurers may come to realize that private physician care is one of the few remaining bargains in the health care market. I

Because physician office-based care is not cost reimbursed, and because overhead is lower, physicians are able to compete effectively on price in precisely those areas which are hospital profit centers—particularly radiology, clinical pathology, and surgery. Further, since there is a direct connection between physicians' activity and their income, there are powerful entrepreneurial incentives both to reduce costs and seek more business. These incentives lead to substitution of technicians for expensive medical specialists in ancillary areas as well as to referral relationships between physicians within the same medical peer groups. Because the physician is largely unregulated, he or she can move much more quickly than the hospital to maximize opportunities.

Physician entrepreneurship presents an uncomfortable long-term dilemma for the hospital administrator. Insurance plans and health maintenance organizations shopping for bargains may increasingly bypass the hospital in seeking certain types of health care. This may strip the hospital of its current profit centers, leaving it a loose, collection of unprofitable operations. Besides creating powerful incentives to develop new lines of business for the hospital, these developments will require rethinking the relationship of the physician to the hospital. Some thoughts about this relationship and the strategic choices facing both administrators and physicians will be found in Chapter 8, *Physician and the Hospital*.

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