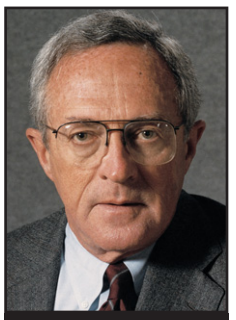
HEART OF THE MATTER

From Cottage Industry to Corporate Medicine

American Medicine has been in transition since the mid-20th century and is about to change yet again into a new model.

It has shifted from a cottage industry comprised of myriad private offices to a corporate model dominated by hospitals and the insurance industry and funded in large part by the federal government.

The cottage industry model had as its philosophic foundation the importance and preservation of the physician's financial and medical independence in dealing with patients. Over time, the transition from physician-owned private practice to multispecialty physician–owned clinics became a natural outgrowth of the complexity of modern medical care. The technological developments in cardiology made a close relationship between hospitals and cardiologists a clinical if not economic necessity.



BY SIDNEY GOLDSTEIN, M.D.

Beginning in the mid-20th century, the American hospital changed from a place where the private physicians could treat pneumonia and remove gallbladders to the current destination of critically ill patients cared for by salaried hospital physicians. The growth of the American hospital can be traced to the huge expenditures by the federal government in the post–World War II years. Since then, hospitals have continued to grow and have become the dominant player in the medical structure of the community.

As health economics changed, however, the need and desire to control the community medical practice patterns led to a variety of financial arrangements between hospitals and physicians, most of which linked the practitioners closer to the hospitals. The shift has occurred as more young physicians—facing major training debt and a reluctance to take on the paperwork required of health insurance compliance—see health care organizations managed by hospitals as a means to a better lifestyle and financial approach to practicing medicine.

The insurance industry's involvement with health care started in 1933, when insurance companies began selling prepaid hospital plans. They were soon consolidated into Blue Cross, which provided depression-era hospitals with needed income and stability. Physicians later reluctantly signed on to Blue Shield in 1944 with the proviso that they would control the plan. The next step was Medicare and Medicaid created in the environment of angry protests from both the American Hospital Association and the American Medical Association during the Johnson administration in 1965 ("The Social Transformation of American Medicine" by Paul Starr [Basic Books, 1982]).

And now we have president Obama's health care legislation, which portends a further evolution of the relationship between hospitals and practicing physicians, particularly cardiologists.

Even before the new health care legislation was passed, the balance between physician-owned and hospital-based practices had undergone major changes. Between 2005 and 2008, the number of physician-owned practices decreased from 70% to less than 50%. The American College of Cardiology estimates that there has been a 50% decrease in private practice in the last year as cardiologists migrated to hospital practices.

For the private cardiologists who own their own clinics, the recent decrease in Medicare reimbursement rates for imaging tests has been the death knell and has forced many to merge their practices with hospitals. The charges for cardiac imaging, which provided much of the financial support for the private physician–owned offices, was the first target of health care planners aimed at decreasing costs by limiting the presumed overuse of outpatient testing. As a result, it decreased testing reimbursement by 27%-40% and accelerated the migration of cardiologists to hospitals.

Paradoxically, if there is no change in utilization, Medicare will end up paying twice as much for a nuclear or echo study as a result of the cost shift from doctor's office fee to hospital reimbursement, according the ACC.

The new model of health care, provided by hospitals and supported by the insurance industry, has now become dominant in many communities. Because of their size and ability to control local practice standards, these collaboratives tend to overwhelm their competition. In Massachusetts, where the new model of health care is playing out, major conflicts have already occurred between hospital-based insurance plans such as Partners HeathCare System, perceived as high-cost providers, and low-cost plans. The Department of Justice is investigating Partners for possible anticompetitive behavior. Although this is not on the scale of Goldman Sachs' misadventures, it is worth noting as we move through the new health care paradigm.

Slowly but surely the American doctor is being incorporated into hospital-insurance alliances supported in a large part by the federal government and private insurers. This may not be all bad, and probably not news to most of you, but it is worth considering how we arrived at this moment in history. ■

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POSTMASTER Send changes of address (with old mailing label) to CARDIOLOGY NEWS Circulation, 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960.

CARDIOLOGY NEWS (ISSN 1544-8800) *is published monthly by Elsevier Inc., 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960, 973-290-8200, fax 973-290-8250. Subscription price is $109.00 per year.*

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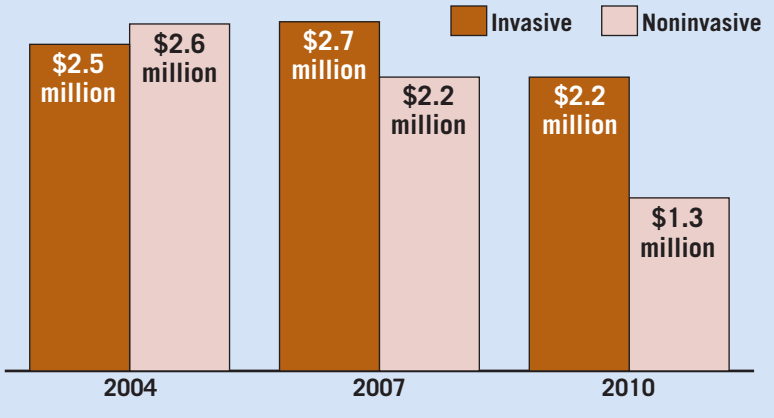
VITAL SIGNS

Annual Hospital Revenue Generated per Cardiologist Down Since 2007



Note: Based on survey responses from 114 U.S. hospitals. Includes hospital-employed physicians and those in independent practice.
Source: Merritt Hawkins 2010 Physician Inpatient/Outpatient Revenue Survey

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