



The Next Wave of Corporate Medicine — How We All Might Benefit

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The thought of “corporate medicine” makes patients and providers panic. Medicine is individualistic; corporations are not. Doctors look out for patients; corporations make money. And yet the

current economic situation is almost certain to increase the importance of corporate medicine. This time, however, there is a twist: providers and patients alike can benefit from the changes that are afoot.

The economic crisis is taking a large toll on health care: the number of Americans without health insurance is increasing, Medicaid payments are decreasing, and hospital endowments have plummeted with the stock market. But the problems in medical care go well beyond the current recession. Even before the recession hit, estimates suggested that the number of uninsured people in this country would rise by 20% in the next

decade.¹ One third of hospital beds are unfilled, despite a 40% reduction in the number of hospital beds per capita since the early 1980s. And the tax-exempt status of not-for-profit institutions is coming under periodic scrutiny.

The hospital industry will be most affected. One quarter of U.S. hospitals are in the red,² and 11% have profit margins of less than 2%. Significant payment reductions without coverage expansions would be problematic. Price increases are unlikely. Medicare and Medicaid reimbursements — which account for nearly half of hospitals’ income — cannot be negotiated, and private insurance

prices have plateaued, after a few years of increase.

Cutting costs is a second option. Hospitals are already reducing the number of nurses, cutting salaries, and postponing major purchases of capital equipment.³ But these adjustments are only temporary. There are fixed costs in the operation and maintenance of facilities and equipment that cannot be reduced and a host of new priorities on the horizon, from the purchase of the latest imaging equipment to investment in computer systems. Financially strapped hospitals will need another course of action.

There are, in theory, two choices: hospitals can close, or they can merge with other hospitals. Hospital closure has become the quiet reality. About 15% of acute care hospitals have closed in the past 25 years. But this is not a viable option for

the long term. There are 30% more emergency room visits today than there were in 1991, despite a 10% decrease in the number of emergency rooms. As a result, half of all hospitals, including two thirds of urban hospitals, report that their emergency department is operating at or over capacity. The situation will become intolerable if emergency access is limited further.

In practice, then, mergers are the only option. In fact, the merger revolution has been proceeding in parallel with the parade of closures. Half of all hospitals are now part of hospital systems. These systems, often anchored by large teaching hospitals, account for 22% of hospital admissions in the largest

metropolitan areas and an even greater share of profits (see table). Big hospitals are reimbursed at higher rates than are small hospitals, have loyal physicians who keep their beds full, and have more money to invest in new facilities and equipment.

The trend, then, will be for financially strapped institutions to seek to merge with their bigger cousins. The question for physicians and policymakers is what to do about this trend. Antitrust policy has traditionally been built on a certain wariness of large provider groups, with a preference for competition rather than consolidation. But opposing the coming merger wave is not an option, because accepting the unplanned failure of

more institutions is not realistic. Far better is to ask the question: as the big institutions absorb their failing competitors, what should we ask of them?

There are three ways such mergers could benefit patients and the medical system as a whole. First, big institutions need to become health centers, not just hospital centers. A hospital system that accounts for a quarter of the market must do more than manage the care of the patients who come through its doors. It must guarantee an adequate supply of primary care everywhere in the community and ensure appropriate access to emergency care. In a way, big health systems will replace state and county health departments, whose budgets have been cut to the bone.

Second, the big health systems need to modernize the health care infrastructure throughout the community. Most big hospitals are investing in information technology in their own institutions. They need to extend this effort beyond their walls. Large, profitable institutions must commit to implementing electronic medical-records systems in every doctor's office and clinic, ensuring interoperability of systems, and facilitating the use of clinical decision aids.

Third, the big institutions need to commit to driving down the cost of care. We tolerate waste in medical care in part because no single institution is in charge. As big institutions get bigger, that will change. There are many ways that health systems can drive down costs. They can work with clinicians to develop less expensive processes of care, such as having nurses provide care instead of physi-

The Size of Large Health Systems.*		
Hospital Referral Region	Largest System	
	Percentage of Region's Admissions	Percentage of Region's Profits
Houston	18	25
New York	22	58
Atlanta	12	15
Boston	23	56
East Long Island, NY	31	34
Philadelphia	20	34
Dallas	19	37
St. Louis	25	47
San Diego, CA	24	40
Pittsburgh	29	54
Orange County, CA	23	45
Minneapolis†	26	14
Columbus, OH	28	52
Miami	19	41
Average among the 82 regions with at least 1 million people	28	35

* Los Angeles is excluded because in its largest system (which has 11% of admissions), hospital profits are not differentiated from those of the physician group.

† In Minneapolis, one hospital system has 29% of the profits but a smaller share of admissions.

cians when possible; they can eliminate medication errors and other costly mistakes; and they can ensure better management of chronic care.

These changes will not happen automatically. About one third of the U.S. population lives in rural or small urban areas where one hospital often dominates the market, yet health care is not better or significantly cheaper in those areas. Clearly, some intervention is required.

Setting specific, measurable goals for community health and medical care is the first step. The goals might lie along several axes: access (not exceeding the lengths of acceptable delays encountered in emergency rooms or in the scheduling of appointments), process of care (increasing the proportion of patients whose care conforms to set standards), technology (adhering to deadlines for implementing a medical-records system), and outcomes (reducing the rates of death or disability from certain causes). The goals need to be agreed on by the provider

and public health communities and measured over time.

Payment systems then need to incorporate these goals. State governments, through the Medicaid program, can work with private insurers and possibly the Medicare program to formulate alternative compensation arrangements for providers. These might include bonuses when providers meet goals of process and outcome, shared savings models that reward providers for health improvements in their patient population, and global or episode-based payment in place of fee-for-service payment. The specific compensation arrangements would be negotiated among health systems, governments, and private insurers, but having specific community goals and a dominant health care system would allow reimbursement changes to have the maximum impact.

A health system configured along these lines would be very different from the corporate medicine of the past. Doctors would be integral to making

such health systems work instead of being dictated to by unaccountable corporations. Patient preferences would be expressed through physicians and the political representatives of the communities in which they live. In many ways, such a system would be closer to a single-payer system than to a traditional corporate model. And it might just work to make health care better for everyone.

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The Shifting Mission of Health Care Delivery Organizations

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An important transition has begun in payment for health care delivery in the United States: organizations that have long been paid for transactions, such as visits or procedures, are beginning — at least in some markets — to be paid instead for producing outcomes. As physicians and hospital leaders contemplate the implications of new payment models, they realize

that the transition will be long, difficult, and messy, with major ramifications for providers.

After decades of discussion about the problems inherent in fee-for-service medicine, skepticism about whether real change is under way would be understandable. But it would be reckless in an environment in which rising health care costs and an economic downturn have intensi-

fied the pressure for cost savings, even as the new presidential administration is seeking to broaden access to insurance coverage. There are probably just two ways to resolve these tensions: providers must be paid less for transactions under fee for service or they must be paid differently. Faced with these options, providers are likely to become increasingly interested in payment reform.