SGR is calculated, have been suggested to correct this problem. These include the use of multiple SGRs (reflecting the differences among specialties in the rate of spending growth) and the use of separate SGRs for multispecialty group practices (encouraging the development of more such groups, which have been associated with high clinical quality and appropriate financial incentives).[2,3] A different way to reduce physicians' spending, and thus some of the downward pressure on physicians' fees, is to have the Centers for Medicare and Medicaid Services (CMS) more aggressively review billing by physicians who are clear outliers in terms of their use of medical procedures and ancillary services, a strategy that appears to be permitted under the Medicare bill that Congress passed in July 2008.

Although all these approaches might provide some short-term relief, I believe the key to reforming physician payment is to develop a more aggregative payment strategy. In the near term, payments need to be developed that cover all the services that a single physician provides to a patient for the treatment of one or more chronic diseases. This approach is consistent with, and could be related to, the work that CMS and others are doing on medical homes. In addition, bundled payments should be developed for high-cost, high-volume DRGs, to include, at a minimum, the reimbursement for all physician services associated with the DRG and perhaps the hospital payment as well. For example, a single payment could be made to cover all physician services and hospital care related to coronary-artery bypass grafting, rather than having each physician bill Medicare separately. In the 1990s, a demonstration of such bundling was conducted by the Health Care Financing Administration, the predecessor to the CMS. The results were promising in terms of clinical outcomes and savings, but as often happens with demonstrations, no further movement has occurred.

At the same time that any interim steps are being taken, I think the CMS should move ahead with a two-part request for proposals — one part for the design, one part for the implementation strategy — that would result in a more fulsome redesign of an aggregated physician payment system. It seems clear that although various models for payment reform are in development, none are currently ready for full implementation by Medicare.[4]

There is no quick fix for physician payment reform. Under the most optimistic of scheduling scenarios, the implementation of a redesigned system is unlikely to occur before January 2013. The first quarter of 2009 is none too soon to start.

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The Independent Physician — Going, Going . . .

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Despite the current focus on expanding health insurance coverage, relatively little attention has been paid to the future of the physicians who provide care for the insured and uninsured alike — specifically, to their ongoing migration from independent solo or small-group practices to larger-group practices, where they are often employees. This trend and its consequences for the care of patients and the practice of medicine have scarcely been explored.

The percentage of U.S. physicians who own their own practice has been declining at an annual rate of approximately 2% for at least the past 25 years. Although the decline is unquestionable, the percentage of physicians currently remaining in independent practice is unknown. For 2001, the most recent year for which data are available from the three usual sources, the American Medical Association (AMA) has estimated the propor-

Percentage of Independent Physicians in the United States, According to Specialty, 1996–1997 and 2004–2005.*

Physician Type	1996–1997	2004–2005	Relative Reduction
		percent	
Primary care physicians	54.3	51.8	4.6
Medical specialists	58.1	47.3	18.6
Surgical specialists	75.5	68.4	9.4

* Data are from the Center for Studying Health System Change, August 2007.

tion at 61.5% and the Center for Studying Health System Change (CSHSC) puts it at 55.9%, whereas the Census Bureau's Current Population Survey calculates it at only 29.3%.

The wide discrepancy is largely attributable to differences in survey methods: the CSHSC count includes only physicians who provide care to patients at least 20 hours per week, whereas the Census Bureau counts all physicians who practice 1 hour or more per week, thus including academic and administrative physicians who practice part-time and are often employees of their institutions. The CSHSC also excludes specialists, such as pathologists and radiologists, who are not generally involved in direct care, as well as federally employed physicians, residents, and fellows. In addition, the CSHSC and AMA survey physicians directly, whereas the Bureau of Labor Statistics queries households and may get its information from family members who are not familiar with the intricacies of medical practice.

Whatever the technical reasons behind the variation among estimates, for those concerned with medical practice and its effect on patient care, it may make a considerable difference whether more than half or only one fourth of the country's physicians are in independent practice.

The decline in physicians in independent practice has been greater among medical specialists than among surgeons or primary care physicians (see table). The low percentage of primary care practitioners in independent practice may reflect the serious problems of overwork and underpayment that primary care fields have faced for many years, which have resulted not only in difficulty with recruiting and retaining primary care physicians but also in the decision by many of them to seek the safety of employment contracts before their specialist colleagues did.

Lack of independence is not, however, exclusively or even mainly a primary care issue. The low or decreasing percentage of physicians in independent practice is not quite the same as, but is intertwined with, the decline of small physician practices (those with 10 or fewer physicians), whose numbers decreased by nearly 15% between 1996 and 2004, during which time the numbers of physician groups of all other sizes (except group- and staff-model health maintenance organizations) were increasing.

This trend raises the question of whether small, independent practices have any future — an important question, since nearly 9 of 10 Americans get their medical care from a physician in a solo or small practice.

The reasons behind the decline in independent practice are complex. Among medical specialists, it may be driven in part by the renewed efforts of hospitals and other large organizations to snap up lucrative specialty practices that they believe will enhance their bottom line. At a more fundamental level, payers' aggressive efforts to clamp down on ever-rising health care costs — through managed care and other reimbursement controls — appears to have been the major driver. Independent physician practices are at a particular disadvantage in contract negotiations, because they are prohibited by antitrust provisions from bargaining collectively. Consequently, they have little economic leverage. Moreover, reimbursement rates have remained stagnant, even as practice costs have risen.

As a result, many independent physicians have seen their incomes decline. This change has hit primary care physicians particularly hard, since their income base is comparatively low. Reports from around the country suggest that this squeeze has led a growing number of physicians to give up independent practice, driving them either into salaried positions in larger organizations or into early retirement. It may also be discouraging new physicians from entering independent practice.

Along with these economic forces, demographic trends, most notably the increase in the proportion of women in medicine, have affected independent practice. Many women physicians, and increasingly men entering practice, prefer the relative financial

security and the shorter hours that come with a salaried position in a large organization. In 2000, 56% of female physicians were employees, as compared with 35% of male physicians.[1]

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

If we have an incomplete understanding of the myriad causes of the decline of independent practitioners, we know even less about its implications, particularly for patient care. The only aspect of this question that has received attention from researchers has been the effect on the quality of care, and the results have so far been mixed. One recent report found that hospital-owned or health plan–owned physician organizations were more likely than independent physicians to engage in quality-improvement or health-promotion activities.[2] Others have found no significant difference in quality of care between independent and employee physicians[3] or that quality of care was somewhat higher among independent physicians.[4]

Effects on other aspects of patient care have only been touched on by researchers. For example, one study showed that the levels of charity care provided remain substantially higher among independent physicians than among employee physicians — an important finding, given the vital role that private physicians play in caring for the country's poor and uninsured populations.[5]

Other, heretofore unexplored, ramifications of the trend might well include effects on the doctor–patient relationship, continuity of care, compliance of patients, and access to medical care in underserved rural communities, where small independent practices are sometimes the only game in town.

The gaps in our understanding are troubling because many of the forces that have been driving the decline of independent practice are likely to persist, and perhaps even intensify, in the coming years. Is this decline something that we, as a society, should be worried about? At this point, the honest answer is that we don't really know. The question has not been a priority for the country's health policymakers or for health services researchers or those who fund them. But, given the fact that independent practice has long been the backbone of American medicine, we would be well advised to try to get some answers — now.

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