Impact of Health Care Reform on the Independent GI Practice

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- Health care • Reform • Gastroenterology • Endoscopy
- Private practice • Independent practice
- Patient Protection and Affordable Care Act (PPACA)
- Affordable Care Act (ACA)

"When nothing is sure, everything is possible"
—[Dame Margaret Drabble, English Novelist, born 1939]

It has been widely recognized that the United States health care system is expensive, fragmented, and ineffective. According to the latest data set from the Organization for Economic Development (OECD), health care expenditures are outpacing overall economic productivity by 2% annually and now account for 17.3% of gross domestic product.[1] The United States currently spends a total of $2.5 trillion per year on health care, or approximately $8000 per person, 2.5 times more than the average developed nation.[2,3] Despite such massive spending, the United States is alone among developed countries in not providing health care coverage for all its citizens, and is being ranked last or second to last in quality, access, patient safety, efficiency, adoption of information technology, and quality improvement, when compared with Australia, Canada, Germany, New Zealand, and the United Kingdom.[4,5] With government budgets increasingly dominated by the need to finance the cost of Medicare and Medicaid, and the country's competitive position in a global market eroding, the political pressure has been rising to fix what is perceived to be a broken system. The health reform law now commonly referred to as the Accountable Care Act (ACA) of 2010 is the most comprehensive effort yet to accomplish this task.

Many have opined that the fragmentation of the health care system, the lack of care coordination between sites of care and providers, as well as a payment system that incentivizes providers to maximize the volume of services, not the value of care,

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are among the fundamental structural issues that need to be addressed. Berwick and colleagues[6] have proposed the "Triple Aim" as a conceptual framework for health reform, describing a set of interdependent goals that need to be pursued simultaneously to achieve high-value health care: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of care of populations. Of importance, these investigators suggest *care integration* as the main vehicle for achieving the Triple Aim. The physician and writer Atul Gawande noted in his recent commencement address at Harvard Medical School that the complexity of medicine now exceeds the capabilities of individual physicians, and that the current structure of the health care system needs to be changed because it "emerged in an era when doctors could hold all the key information patients needed in their heads and manage everything required themselves."[7] Gawande further notes that in 1970, it took 2.5 full-time equivalents (FTEs) to take care of a typical hospital patient when today, due to the increasing complexity of medicine, that number has risen to more than 19 FTEs. He concludes that the complexity and range of required specialized skills force teamwork and well-tested protocols. Providers need to work more as "pit crews" and less as "cowboys," that is, system changes are necessary that encourage better communication and coordination between providers as well as transparency in measuring and rewarding quality performance. Therefore, while the need to reform the health care system has been long recognized and many efforts have been made, the recent passage of the ACA promises to accelerate this evolution with a specific emphasis on care integration, transparency in the pursuit of quality care, and accountability for and management of shared financial incentives.

CURRENT STATE OF GASTROENTEROLOGY PRACTICE

Before discussing the transformative impact of health care reform on gastroenterology (GI) practices, it is useful to take stock of the current state of GI in this country. Our specialty stands out among internal medicine specialties for its large proportion of ambulatory care and its procedure orientation. Gastroenterologists typically spend most of their time in ambulatory endoscopy units and in the office, focusing on colorectal and esophageal cancer prevention and on patients with a variety of prevalent disorders such as gastroesophageal reflux disease, liver problems, and inflammatory bowel disease. GI is a mostly consultative specialty, and as such is dependent on referrals from primary care providers. American medicine traditionally has been a "cottage industry" with most medical care being provided in small, privately owned practices. GI is no exception. According to recent surveys by the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), approximately 80% of the 11,000 clinical gastroenterologists in the United States are practicing outside of academic medical centers.[3] (John Allen, AGA membership survey 2010, personal communication.) There has been a slow trend toward practice consolidation, but as of 2009 at least 50% to 60% of GI practices still had 4 or fewer physicians, and fewer than 20% had 11 or more physicians. Roughly half of private-practice gastroenterologists have a financial interest in an ambulatory endoscopy center (AEC). Informal estimates suggest that in 2012, approximately 65% to 70% of practice revenues are derived from procedures and related services. Although this makes GI practices uniquely vulnerable to disruptive technologies, at present endoscopy continues to be a key diagnostic tool and colonoscopy remains the preferred technique for colorectal cancer screening. Thus, any trends that put pressure on small practices or disproportionately affect procedure revenues