Radiology Isn’t Alone In Commodityization

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Radiology continues to be threatened by commoditization, but it’s also a threat looming for health care as a whole.

For nearly a decade, there has been a growing fear in radiology that the specialty is barreling toward commoditization – a shift that would simultaneously devalue radiologists and the services they provide. Industry experts and on-the-ground practitioners have rightfully wrung their hands and tried to identify strategies to change the tide, but, in doing so, they’ve paid little attention to the fact that this isn’t a new problem and radiology isn't alone.

In fact, the commoditization of specific medical fields is decades old. Various specialties have fallen victim, and now the phenomenon is encroaching on the health care industry as a whole. “It’s been slowly moving in this direction for the past decade. For many years, manufacturing believed in economies of scale, and there’s been a lot of consolidation in industries,” said Jeff Mason, president and CEO of Wisconsin-based health care consulting firm Analytics-LLC. “As much as people like to think that health care is different and that it isn’t subject to some of the same forces as other industries, it is.”

Health care is just like any other free market when it comes to the concept of competition, he said. And the factors pushing things in this direction are many – from federal reimbursement shifts to consolidations to changes in the ideology surrounding physicians. Taken separately, the structure of medicine likely would have remained the same with independent practitioners controlling how they spend their time and how they treat patients. Together, however, medicine – and radiology – is fast becoming a commodity to be sold to the lowest bidder.

**Medicare’s Role**

Though it’s a relatively new buzzword, the move toward greater commoditization started nearly 30 years ago when Medicare established its own fee schedule for services rendered. Rather than continue paying hospitals based on percentage of what they charged, Medicare, as the largest national payer, created the diagnosis-related group (DRG) system that no facility could refuse. The cost cut was significant enough for larger organizations, Mason said, but smaller ones took the hit even worse. The result: mergers, acquisitions, and consolidation.

“Small providers, hospitals, and physician groups were taking such a deep discount that they got into financial trouble. They weren’t able to cover their costs and make a reasonable compensation,” he said. “Their solution was consolidation. They had to run to a larger health system to buy them out for the value of their referrals.”

Consolidation momentum birthed commoditization, he said. And, it’s still going strong. According to a 2014 Becker’s Hospital Review survey, 85% of health care respondents expected mergers and acquisitions to increase in health care within the coming year. A 2012 *Diagnostic Imaging* survey supports those findings – 70% of radiology respondents had concerns over being acquired and losing business.

There is a potential upside, though, Mason said. In exchange for whatever independence a physician loses in an acquisition, he or she gains the brand recognition of the purchasing institution.
A Doctor By Any Other Name...
Patients still mainly talk about seeing their doctors, but it’s becoming more commonplace to hear the term provider used to identify the health care professional offering services. Not only does this moniker include doctors, but it also refers to nurses, physician assistants, and any other personnel performing some type of health-related activity. Collectively, they’re also known as physician extenders.

Switching terminology from doctor to provider doesn’t have a monetary impact on the practice of medicine, but it could change how people perceive the level of education and experience needed to provide quality medical care. A growing number of patients are becoming comfortable having physician extenders meet the bulk of their needs.

There’s little that can be done about this commoditizing factor, though, Mason said. “We have had a significant physician shortage in the United States to-date. Based on that, health systems have turned to physician extenders to meet its needs,” he said. “It helps to solve the physician shortage, but it also takes power away from the physician.”

Currently, there are court cases in several states, pushing for physician extenders to have expanded power to practice. Legal success would mean these providers could offer many of the same services as a doctor, but at a lower cost, he said.

Is Radiology Alone?
There’s no question, according to industry experts and data, that radiology has already become commoditized to a degree. “Radiology is the top area of commoditization based on the fact that teleradiology has made the delivery of radiology services almost frictionless,” Mason said. “You can get it wherever you need it. You don’t need a radiologist onsite.”

Radiology’s commoditization didn’t take long once it was possible to get radiology services from anywhere in the world at any hour, and consumers started shopping around for the best price. And, it’s easy for radiology to perceive itself as an island, the lone specialty being undercut by cost-control and consolidation winds. But, that’s not the case. There are other specialties feeling the same pinches, he said, including emergency medicine and anesthesiology.

Although telemedicine isn’t possible with emergency services, it is shift work. Increasingly, hospitals and health care facilities are finding and hiring health professionals — usually doctors with less training and experience or physician extenders — to cover unmanned shifts for the best price. Doing so often comes at the expense of quality care, Mason said.

According to Sunny Sanyal, CEO of emergency medicine health technology company T-System Inc., emergency medicine can fight commoditization the same way radiology has — by integrating itself into hospital-wide activities and conversations. Emergency medicine physicians can help design programs that direct patients toward the most appropriate care venues, such as outpatient clinics or urgent care centers.

They can also assist in setting up a hospital-associated referral base. For example, if a patient with chest pains leaves the emergency department after observation, his or her physician can connect them for a follow-up appointment with a cardiac specialist in the community who is also tied to the hospital. Successfully doing so can bolster the health system’s bottom line.

Anesthesiology faces the same problems, according to Mark Hudson, MD, vice chair of anesthesiology at the University of Pittsburgh School of Medicine. Across the country, anesthesiology, like radiology, departments are being replaced by lower-cost groups who provide the
same services.
“Anesthesiology management companies are proliferating rapidly, thriving on the commoditization
of anesthesiology care with polished sales pitches aimed at hospital leaders who must reduce cost in
the current U.S. healthcare environment,” Hudson wrote in a January 2014 editorial published in the
Austin Journal of Anesthesia and Analgesia.
Their tactics for survival mirror those from radiology and emergency medicine, as well.

**Physician Response**
The question of whether physicians, in the face of commoditization, are losing their vested interest in
providing the highest quality patient care independently is one open for debate. According to a 2012
American Medical Association report, 60% of doctors worked in physician-owned practices. Only 23%
worked for practices wholly- or partially-owned by a hospital, and 5.6% were strict hospital
employees. However, Merritt Hawkins, the physician recruitment firm, anticipated 75% of
newly-hired physicians in 2014 would be hospital employees.
A Becker’s Hospital Review survey that looked at independent physicians between 2013 and 2014,
though, found the number of self-employed doctors looking to sell their practices grew from 21% to
24%, and physicians hoping to remain independent dropped from 60% to 53%.

**The Challenges of Medicine’s Commoditization**
The biggest pitfall of commoditizing medicine, Mason said, is that it chips away at the relationship
between patient and physician. For many doctors, that connection is the most treasured part of their
profession.
“Many doctors see that relationship as being the reason they became a physician,” he said. “The
value of knowing the patient and having a personal relationship with them is high. You take that
away by forcing doctors to see to many patients per hour, and you’ve reached a situation where the
physicians want greater pay to offset the loss of something that’s so important to them.”
That’s a significant loss from the patient’s perspective, too, as a good doctor-patient relationship
depends largely on trust. But growing commoditization strictly limits that face-to-face time, carving
away at a patient’s comfort level and devaluing what services and advice the doctor offers, he said.
Although it carries challenges and can potentially change the practice of medicine significantly,
commoditization could support the latest push to control health care costs. As more newly-insured
people enter the health care system and begin to shop around to meet their health care needs, not
only will services become more standardized, but hospitals and individual providers will lower their
prices to stay competitive, as well.
Ultimately, Mason said, medical practice will be different for physicians as the industry embarks on
new care and payment models.
“They’re going to be expected to produce at a very high volume and, hopefully, at high quality.
They’ll either find new motivators or they’ll move on because they’re not comfortable with the
structure,” he said. “The more we commoditize, the less likely they’ll get value out of personal
relationships. They’ll look for other things, such as more money, shift work, days off, or limited call
schedules. Necessity is the mother of invention, however, and we’ll find a way to solve it.”

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