Comparative Analysis: Physician Practice Evolution

EXAMPLE PAPER

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Note: This is an example paper written on the e*volution of physician practices*. The actual assessment is a comparative analysis of the *evolution of hospitals*.

Comparative Analysis: Physician Practice Evolution

In this comparative analysis report, the evolution of physician practice is reviewed from the 1800's through the 2000s. The purpose of this report is to show the progress of how physician practices, their staff and payment systems have changed over the last three centuries. The irony is that they have changed, and they have also gone full circle as explained below.

In the 1800 and 1900 centuries, the relationship with the physician was very personal and patient-centered. The physician knew everything about their patient, and the patient knew everything about their hometown physician. As medicine evolved, physicians became more specialized, and focused on specific diseases. This often removed that personal relationship between physician specialist and patient. The irony is that the 2019 COVID pandemic put a spotlight once again on the primary care physician-patient relationship, but in a much broader context. The pandemic showed us the importance of the primary and community healthcare (P&CHC) systems focus (Lauriola, et al., 2021). The pandemic revealed a weakness in P&CHC worldwide, i.e., it put a focus on hospital and intensive care beds and not on community and primary care. In Lauriola et al. (2021), the authors propose that the pandemic has shown us that P&CHC is where the focus needs to be though local community problem-solving to safeguard communities, which brings us back to the primary care physician and infrastructure at the community level, but in a context of global world health (Lauriola et al., 2021).

Comparative Grid and Analysis

In Appendix A, the table entitled *The Physician Practice Evolution and Changes* shows how the physician practice has progressed. There are several major milestones that stand out in the table which includes the evolution of the physicians' offices, the training of their staff, and how they were paid compared to payment systems today.

The Physician Practice

In the 1800s, physicians would often go to see the patient at their home (Nespor, 2009). Physicians were solo practitioners around the turn of the 19th century. By the mid-1900s physicians were more likely to be in a group practice of two or more providers (Kroth & Young, 2018). In the early 1990s, healthcare markets began to consolidate nationwide due to rising healthcare costs and reduced reimbursement. By the 1990s group practices began to integrate horizontally into Independent Practice

Associations (IPAs) (Kroth & Young, 2018). The IPAs then vertically integrated with hospitals and formed Physician-Hospital Organizations (PHOs). The PHOs were established to retain and gain market share through managed care contracting and used shared purchasing groups to achieve cost-savings (Kroth & Young, 2018; Williams & Cuneo,1997).

Physician Staff

In the 1800s, the physician most often worked as a solo practitioner without an assistant. If they had an assistant, it was someone that they personally trained (Nespor, 2015). By the 1960s, due to population growth and the demand for health services, physicians time became a scarce commodity, and the nurse practitioner movement began (Kroth & Young, 2018). This movement persists today because of population demand and the projected physician shortages (AAMC, 2021).

Payment Systems

From the 1800s to the early 1900s, physicians were paid in small amounts of cash, or in food and services from their patients (Allen, 2016). As healthcare costs rose between 1960-2000, physicians' fees declined. The physicians' reimbursement changed from fee-for-service to discounted fee-for-service and capitation (Kroth & Young, 2018). Capitation is a flat prepaid fee to providers per member per month (PMPM) from the managed care organizations (MCOs) (Kroth & Young, 2018).

Comparative Analysis Summary

In the 1800s, the physician's office was often their home. By the 1960s offices were centrally located and often group practices with two or more physicians. In the 1800, physicians extenders did not exist. In the 1960s and still today the educational programs for NP and PA are well established and the physician extender, working under the supervision of the physician, is common.

One of the biggest changes in the physician practice has been in the reimbursement for their services. In the 1800s, physicians received payment in cash or food and services. Blue Cross (BC) was established in 1929, Medicare and Medicaid in 1965 as fee for service payers. However, by the early 1990s markets consolidated and managed care organizations were on the rise promoting care quality and cost containment.

Conclusion

In conclusion, the evolution of the physicians practice has been progressively positive, and the improvements have established higher quality of care in medical practices today. The changes in the physician's medical practice have been and will continue to be dynamic and persistent. However, the medical industry is unable to ignore what the 2019 COVID pandemic has revealed, i.e., the importance of the primary and community healthcare (P&CHC) systems focus. Although, the primary care and specialty care physicians will continue to manage patient care and prevention at the community level they will need to do so within a broader world-health context.

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Appendix A

The Physician Practice Evolution and Changes

Theme	1800s	1960s	2000s
The Physician's Office	• Often the providers home • Often the patients home (Nespor, 2009).	• Single Physician Office (Nespor, 2009). • Small group Practice of 2-4 physicians (Kroth & Young, 2018).	• Independent Physician Associations (IPAs). • Consolidation of market with larger physician groups contracted with Hospitals, i.e., Physician Hospital organizations (PHOs). (Kroth & Young, 2018).
The Physician Assistant	• None with formal training. • Trained by the physician to assist them (Nespor, 2015).	• Office staff, may include RN, LPN, or MA • Often trained by the physician to assist them (Kroth & Young, 2018).	• Specialization, Physician extenders, Nurse practitioners (NP) and Physician Assistants (PA) • Lab Technicians, Radiology Technologists (Kroth & Young, 2018).
The Physician Payment Systems	• Small cash payments • Goods, such as coffee, tea, wine, and beer; and services such as carpentry, painting and so on were offered as payment (Allen, 2016).	• Fee-for-Service: Private pay. • Early insurance payments form BCBS (1929), • 1965 and beyond, Medicare and Medicaid (Kroth & Young, 2018).	• Medicare Physicians Fee Schedule (PFS), Resource-Based Relative Value Scale (RBRVS), • Capitation, one fee per member per month (PMPM) (Kroth & Young, 2018).

