STRATUM HEALTH ADVISORS

CASE STUDY N° 23 · DECISION ANALYSIS

Employ, Affiliate, or Let Them Go

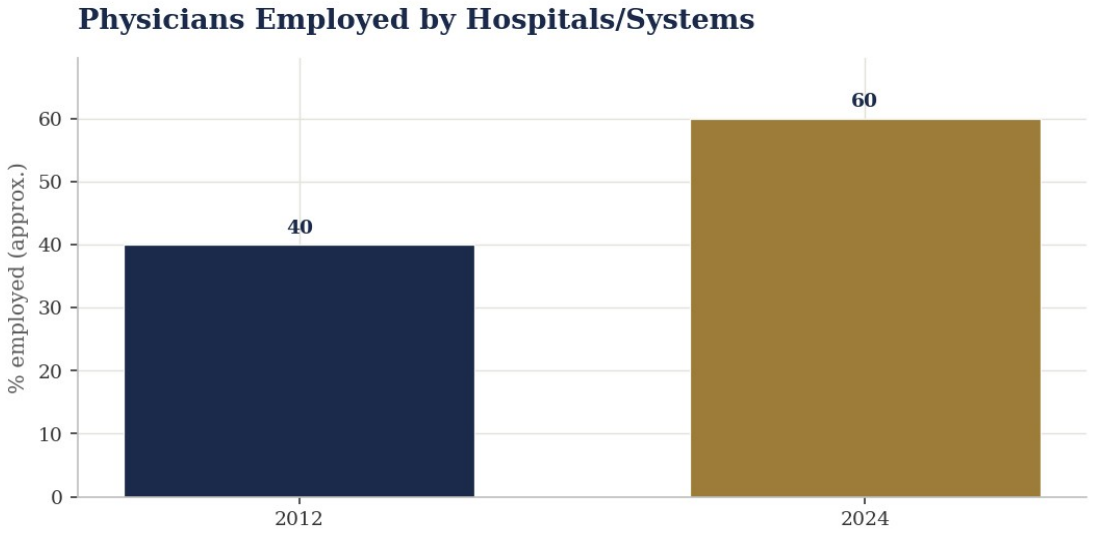
As physician independence falls, health systems must decide which practices to employ, which to affiliate, and where competition makes each choice right — a decision that plays out differently in rural referral capture than in urban rivalry. A health-system integration and geography analysis.

1. The Fork

A regional health system watching physician independence decline must decide how to relate to the physician groups in its market: employ them outright, affiliate through looser arrangements, or let competitors and PE-backed platforms absorb them. The right answer depends heavily on the system's competitive geography — a rural system protecting a referral base faces a different calculus than an urban system fighting well-capitalized rivals. This is an analysis of the employ-affiliate-or-cede decision through that geographic lens.

2. The Landscape Before the Decision

The broad trend is the disappearance of independent practice: physicians in private practice fell from about 60% in 2012 to 42.2% by 2024, with hospitals, systems, and PE-backed platforms absorbing the difference[1]. For a health system, every independent group in its market is now a question: employ, affiliate, or watch a competitor take it.



Illustrative | Source: AMA Practice Benchmark trend.

The strategic stakes are about referral control. A physician group is a source of downstream referrals — surgeries, imaging, specialty care — that flow to whoever controls the relationship. When a system employs or tightly affiliates a group, it captures those referrals; when a competitor or a PE platform takes the group, the system loses them. Vertical integration is, at its core, a fight over which institution captures the referral stream a physician group generates.

3. The Decision Logic — Steelmanned

Employment is expensive and operationally heavy — salaries, infrastructure, the management burden of running physician practices — so the instinct to employ everything is often wrong. The steelman for selective employment is that a system should employ where referral capture is strategically essential and affiliate or cede where it is not. In a rural market where the system is the only regional hospital, employing or tightly affiliating the primary-care and specialty base protects the referral stream that keeps the hospital's high-margin services full — losing that base to an outside platform could hollow out the hospital. In a competitive urban market, by contrast, employing every group is a costly arms race; the system may do better affiliating selectively and competing on quality and network for the referrals rather than owning every practice outright.

4. The Landscape After

The geographic asymmetry drives the decision. In rural and less-competitive markets, referral capture is existential and the field of rival acquirers is thin — so the system's move is to secure the essential referral base through employment or tight affiliation before an outside PE platform enters and redirects the flow. The rural system's advantage is that it is often the natural home for local physicians; its risk is complacency, assuming independence will persist until a platform proves otherwise. In urban markets, referral capture is contested by multiple systems and platforms simultaneously, employment is an expensive way to compete, and the durable strategy is usually selective — employ the strategically critical groups, affiliate the rest through arrangements that capture referrals without the full cost of employment, and compete on network breadth and quality.

The failure mode is applying one integration strategy across a mixed footprint. A system that employs aggressively everywhere overpays in competitive urban markets where affiliation would suffice; a system that affiliates loosely everywhere risks losing its essential rural referral base to a platform that employs. The right posture is geography-specific: aggressive securing of referral bases where they are existential and acquirers are few, selective and cost-disciplined competition where the market is contested. Integration is not a philosophy to apply uniformly but a market-by-market calculation about where referral capture is worth what it costs.

5. The Strategic Read — For Any Regional Health System

The employ-affiliate-or-cede decision turns on competitive geography and the strategic value of referral capture. The tradeoff space:

MARKET TYPE	RIGHT POSTURE	THE FAILURE MODE
Rural / sole regional system	Secure essential base — employ or tightly affiliate	Complacency — losing the base to an entering platform
Competitive urban	Selective employment + affiliation; compete on network	Costly arms race — employing everything
Mixed footprint	Geography-specific posture per market	One uniform integration strategy everywhere

6. The Stratum Outlook

> **IN PLAIN TERMS**
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> Strip away the mechanics and it is this: doctors are going from mostly independent to mostly employed, and every independent group in a hospital's area is now a choice — hire them, partner loosely with them, or watch a competitor grab them and the patient referrals they send. The right move depends entirely on where you are. If you are the only hospital in a rural region, those referrals are your lifeblood, and you should lock in the essential groups before an outside investor shows up and reroutes them. If you are one of several systems in a city, trying to employ every practice is an expensive war you may not need to fight — partner selectively and win referrals on quality instead. The mistake is one-size-fits-all: hiring everyone where you do not need to, or partnering loosely where you cannot afford to lose the base. It is a map decision, not a policy.

7. Where Stratum Fits

A health system needs each submarket classified by competitive intensity and referral-capture stakes to decide where to employ, where to affiliate, and where to compete on network. Stratum builds that integration map. Start a conversation at stratumhealthadvisors.com.

References

All figures in this analysis are drawn from the following public sources, current as of publication (July 2026).

[1] AMA Physician Practice Benchmark Survey via Becker's / Ophthalmology Management (private practice ~60% in 2012 → 42.2% in 2024). Employment-share figures shown are illustrative of that documented trend. Referral-capture and integration dynamics per GAO-25-107450 (2025).

Figures reflect the most recent public sources available and may change as ownership and market conditions evolve. This reference list is provided for transparency and does not constitute an endorsement by the cited parties.