

PHYSICIAN PRACTICE OPTIONS

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The Future of Health Care Doctors in all Settings are Grappling with the 11 Realities of Managed Care

As health care evolves from a provider-driven to a market-driven system, physicians are understandably divided, bewildered, and confused about how to deal with reality. In the words of one commentator, Daniel A. Gregorie, president of Choice Care, an HMO in Cincinnati, "Physicians are angry, frustrated, and to some extent, depressed because the world as they know it is changing rapidly and radically."

Change is coming as medicine is transformed from a profession into an industry. At the same time the health care pyramid has been inverted. At one time academic medical centers, hospitals, and physician specialists were on top; PCPs, corporate payers, health insurers, and managed care companies were on the bottom. Today, the opposite is true.

Physicians need to react to the realities of managed care, to evaluate carefully their practice options, and to adapt quickly to the new rules and the new realities. After discussing these new realities in interviews with physicians in a variety of practices nationwide, *Physician Practice Options* believes they can be explained in the following 11 points.

The New Realities

1 Managed care and integrated systems of care are inevitable and will cover 90% of the non-Medicare, non-Medicaid population by 2000. At that time, most independent practices and independent hospitals will be obsolete.

Comment: Managed care and integrated systems of care are inevitable, but a "second-tier" of medicine also exists. Managed care

will control only 50% to 75% of the total U.S. market, and physicians and consumers will continue to resist managed care penetration. Today, industry sources say that 70% of all Americans are in some form of managed care plan.

2 Medicare and Medicaid populations, which represent 50% of hospital patients and 40% of outpatients, will be privatized, shifting vast populations to risk-bearing HMOs run by for-profit entities.

Comment: If all Medicare and Medicaid patients switch to HMOs, managed care organizations will dominate in every market. Currently, 9% of Medicare and 27% of Medicaid patients are in HMOs. Such a shift would have a significant effect on how health care is delivered, meaning market forces and the drive to control costs would prevail over individuals' concerns about physician choice.

3 A re-emergence of physician enterprises as the core of the health care enterprise is under way in the form of PHOs, IPAs, medical service organizations, and physician management corporations. Much of the capital for these enterprises is coming from Wall Street.

Comment: Among doctors, opinions differ sharply on the ability of physicians to organize themselves, on the source of capital, and the influence of Wall Street. Most doctors believe capital is coming from physicians and hospitals and that Wall Street investors should not be trusted. Many express doubt about the ability of physicians to seize the business side of health care. There is substantial agreement, however, that whoever provides the capital will call the shots.

(Continued on page 3)

Focusing on Your Practice Options

Physician Practice Options represents the continuation of *The Reece Report*, a 10-year-old newsletter for physicians. Though we have changed the name and the design, the mission remains the same. Like *The Reece Report*, *Physician Practice Options* is designed

- To empower physicians in the face of the new realities of managed care;
- To motivate doctors to reposition their practices;
- To provide physicians with the information they need to be a stronger force in the market.

Serving Readers

We are making these changes to serve our readers more effectively in three specific ways:

1. *Physician Practice Options* has greater access to resources. Since *The Reece Report* was produced almost entirely by one person, our resources were limited. Our new publisher, Premier Health Care Resource Inc., in Chatham, N.J., provides backing by major pharmaceutical companies and health service providers; an editorial staff headed by Joseph Burns, former editor of *Business & Health* magazine; and a working editorial board, each of whom is an expert in some phase of managed care.
2. *Physician Practice Options* will focus on the issue of how doctors organize their practices. As physicians, we are becoming more important players in the business of medicine. Our income alone accounts for 20% of the \$1 trillion spent on health care, and we are directly or indirectly responsible for spending the other 80%. While we control much of the spending, we are fragmented: More than 600,000 doctors practice in some 400,000 locations. Some 70% of us are either in sole-proprietorships or in small groups. We must organize ourselves into larger, more economically effective groups to protect our income, our autonomy, and our patients.
3. *Physician Practice Options* will focus on physicians' need for strategic information. The complex competitive pressures inherent in today's practice environment require that doctors have expert advice. Should you join an HMO or PPO? Should you form an IPA or other integrated group? Should you sell your practice? Should you form a partnership with a hospital, a practice-management firm, or an HMO?

New Realities, New Rules

The transformation from the traditional fee-for-service system to managed care involves two fundamental changes. The first involves the integration of physician services with hospitals, health care buyers, insurers, and other providers. The second involves the aggregation of physicians into larger networks, which ought to be physician-driven. The astonishingly rapid metamorphosis from a fragmented health care system into a far-flung business enterprise of integrated and interdependent organizations involves many new realities, new rules, and new responses. Most physicians today are working in new organizations, preferably their own. They are following new rules, guidelines, or protocols, preferably ones they have written themselves. Physicians are destined to become the new leaders in a new competitive environment that will require new capital, new management competencies, new marketing expertise, and new information systems. In short, the new medicine is upon us.

To help our readers thrive in this new environment, the staff of *Physician Practice Options* is creating a new newsletter, one that helps physicians understand the new rules and control their destiny. We will identify the best and most successful practices so that you can learn from them. We will identify trends as they develop so that you can react to them. We will identify strategies that are working so that you can put them to work for you.



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4 Physicians should control health care because only they can deliver care, only they can control costs, and only they can persuade other physicians to change their behavior to thrive under managed care.

Comment: Doctors are reluctant to embrace the notion that physicians have the power to “control” health care. Many believe that cost control will be a team effort and that other players and other providers already have seized control. Physician dominance would be ideal, but difficult, because many doctors believe that physicians cannot get together in a cohesive group to effect change. One area in which physicians already dominate is the physician-owned managed care groups in California, such as Bristol Park Medical Center, Friendly Hills Health Care Network, and Health Care Partners Medical Group. These groups have dramatically lowered costs and hospitalization rates.

5 Medical groups face a price-competitive world. To compete, these groups, and physicians in general, need capital, management infrastructure, and strategic partners. These needs may be fulfilled by hospitals, insurers, or physician management companies. Of these three choices, management companies may be the best because they are most likely to offer physicians equity and clinical control.

Comment: Doctors disagree about which organizations best fulfill the need to make physicians competitive. Most doctors agree that hospitals and insurers currently are in control and that hospitals are better partners than practice management companies.

6 Capitation is coming fast and will reverse economic incentives by rewarding less care rather than more care. Capitation also demands broadly based primary care networks and results in a surplus of specialists and hospital beds.

Comment: There is broad agreement among doctors that there are too many specialists. But at least some doctors object to the statement that capitation rewards “less care.” Some say capitation may deliver the right care, in other words, appropriate care, no more than necessary and no less. Currently, 60% of managed care plans use capitation in some form, and 15% to 25% of physicians provide care to patients in capitated plans.

7 One of the most significant parts of the Medicare reform bill is the lowering of antitrust barriers, the allowance of physician-pricing, and the setting aside of the provision of large cash reserves for “provider-sponsored networks.” These networks, which are, in essence, PHOs, would be allowed to bid for risk-bearing Medicare and Medicaid contracts.

Comment: In general, doctors say provider-owned plans are capable of assuming risks for Medicare and Medicaid groups. These groups have significant revenue-producing potential. Allowing physician-hospital organizations to bid and assume risk

equity corporations; or equity-partnerships among hospitals, insurers, and physicians will be necessary for doctors to have enough capital and expertise to contract with powerful big buyers.

Comment: Few doctors disagree on this issue. Integration, doctors say, is necessary to win managed care contracts. Integration, capital, contracting expertise, cooperation, and consolidation all will be necessary in the future.

10 The successful physician organizations of the future will likely be rooted in large networks of primary care physi-

Integration, doctors say, is necessary to win managed care contracts. Integration, capital, contracting expertise, cooperation, and consolidation all will be necessary in the future.

without burdensome regulation or financial reserves will level the playing field for hospitals and physicians as worthy managed care competitors.

8 The four major economic forces driving the shift to managed care are:

1. The demand among corporate buyers for lower costs;
2. The massive repositioning and consolidation of major health care industries in anticipation of managed care;
3. The lowering of antitrust barriers to consolidation; and
4. Expectations that most future health care will be provided on the basis of low-cost bids.

Comment: Market forces, particularly demand for lower premiums, are driving the shift toward managed care. Price is much more important today than quality, physician credentialing, access to care, clinical guidelines, an emphasis on prevention, or outcomes measurements.

9 Physician-hospital integration, in the form of PHOs or provider-sponsored networks; physician to physician integration, in the form of POS, MSOs, or physi-

cians with access to capital and capitated subcontracts to hospitals and specialists.

Comment: Fundamentally, there is widespread agreement among doctors on this issue. A few nay-sayers, however, claim that capitation will engender poor quality patient care and large plaintiff attorneys’ fees.

11 The American medical specialist is more resilient than managed care purists would have us believe. Certain specialists—ophthalmologists, oncologists, urologists, cardiologists, behavioral specialists, occupational medicine specialists, and endocrinologists taking care of diabetics—are already forming national carve-out chains to prepare for capitation; and new technologies—such as the laser to correct nearsightedness and the coronary stent to improve by-pass results—will continue to be developed to support certain specialties.

Comment: The development of specialist carve-out chains, the cost efficiencies of certain specialists in caring for certain diseases, the political power and prestige of specialists, and the belief of Americans in the power, pursuit, and perfection of technology assure the future of specialists. ☪

The Five Stages of Managed Care Development

Physicians facing managed care market-driven reform will find it useful to understand the various stages markets go through as they move from fee-for-service to fully capitated care. Each stage is distinguished by specific characteristics.

Although managed care is a national phenomenon, it is implemented locally. California, for example, is widely viewed as having one of the most mature managed care markets. Most other sections of the country do not have California's large medical groups, its managed care infrastructure, or its traditions. Managed care in other regions depends more on hospitals as the hub of health care delivery. Hospitals, therefore, and not physicians, tend to form integrated systems. Lately, however, venture capital from Wall Street and other investors has shifted from biotechnology to health services. As a result, money has been going to practice management companies and to carve-out specialty groups, which for now at least, have high price-to-earnings ratios and the promise of high sell offs later.

What follows is one of the more commonly cited market stage scenarios. It was developed by the University Hospital Consortium in Oak Brook, Ill.

Stage One

Physicians cling to independence in this stage. The market is characterized by:

- Independent hospitals, physicians, employers, and HMOs;
- Few affiliations;
- Utilization is high in doctors' offices and in hospitals; and
- HMOs are serving less than 10% of the population.

Among the cities included in this stage are Birmingham, Al., Chapel Hill, N.C., Galveston, Texas, Greenville, N.C.; Harrisburg, Pa.; Little Rock, Ark.; Morgantown, W.Va.; Newark, N.J.; Omaha, Neb.; and Syracuse, N.Y.

Comment: These markets are maturing rapidly. Some observers believe that Birmingham, Chapel Hill, and Greenville have already moved into stage two.

Stage Two

HMOs and PPOs force doctors to align in this stage. The market is characterized by:

- Loose provider networks and weak hospital affiliations;
- Excess patient capacity; and
- HMOs are serving 11% to 30% of the population.

Examples of cities in stage two include Atlanta, Baltimore, Cincinnati, Indianapolis, New Orleans, New York, Philadelphia, Pittsburgh, Richmond, Va., St. Louis, and Tampa and St. Petersburg.

Comment: This stage is transitional and short-lived, especially in major metropolitan areas. These markets can develop into stage three quickly because of certain precipitating events. Such an event might include any one of the following:

- A major HMO enters the market;
- Large businesses form a coalition;
- Government employees are shifted into an HMO;

- Columbia/HCA, or some other large hospital chain, buys a local hospital;
- Several large HMOs target the area as a major market for expansion;
- Medicaid or Medicare participants are shifted into risk-bearing HMOs;
- Many Blue Cross patients are shifted from indemnity into prepaid plans;
- An aggressive primary care group is formed; or
- A large integrated system forms its own HMO in the market.

Stage Three

Hospitals make a pitch for integration in this stage. The market is characterized by:

- Large HMOs, PPOs, or medical groups achieve a critical mass of patients and begin to consolidate;
- Hospital systems form. They recruit aggressively and compete to buy primary-care group practices;

How Managed Care Came to

The question many physicians are seeking to answer is this one: How did we get from a high-tech, resource-rich, specialist-dominated health care system controlled by professionals to a market-oriented system dedicated to primary care, emphasizing outpatient care and focusing on cost reduction? The answer is that this shift happened quickly over the last two decades—and particularly in the last five years—but the roots of this change were planted in three revolutions that occurred in this century:

- 1) the scientific revolution at the turn of the century, 2) the revolution that health care is a social good, and 3) managed care itself.

1. The Scientific Revolution

This revolution occurred because of excesses in medical education. In 1910, Abraham Flexner, an educator who founded the Institute for Advanced Study, in Princeton, N.J., wrote a report

on medical education that came to be called the Flexner Report. As a result of this report, many medical schools were closed and others were changed radically. What evolved were modern medical schools with full-time faculties dominated by specialists. Today, we have 125 medical schools producing 17,000 graduates each year, and 80% of them are specialists or subspecialists. This domination by specialists is seen by many to be one of the forces driving up health care costs nationwide.

2. Health Care as a Social Good

This revolution occurred during World War II. At the time, a number of events happened at once: Millions of soldiers were exposed to first-rate medical care; the U.S. government made the cost of health care benefits tax deductible for employers that offer such benefits to workers; and millions of Americans suddenly had access to

- Hospitals close or shut down wings to reduce the number of beds; and
- Some 31% to 50% of the population gets health care through HMOs.

Some examples of cities in this stage are Boston, Chicago, Denver, Detroit, Houston, Milwaukee, Phoenix, San Francisco, Seattle, Tucson, Ariz., and Washington, D.C.

Comment: This stage also can be short-lived. Major players will quickly see that hospitals are no longer the center of health care in these markets. Physician-hospital organizations (PHOs) may form quickly but fail to thrive because of conflicts of interest between hospitals and doctors. Such conflicts are acute if the hospitals involved remain fixated on filling beds and building patient revenue since their partners—the doctors—are rewarded under managed care for not hospitalizing patients. Hospitals and their corresponding PHOs must become more efficient and drive down costs in order to be competitive in the face of pressure from payers.

Stage Four

In this stage, capitation, the most rigorous form of managed care, begins to spread. The market is characterized by:

- Purchasers contract with integrated medical groups and hospital-physician systems to provide comprehensive services to plan participants;
- Capitation spreads widely, and fee-for-service medicine and doctors in solo practices cannot survive;
- The financial risk of providing care shifts to primary care medical groups;
- HMOs are serving more than 50% of the population.

Examples of cities in this stage include Los Angeles, Minneapolis, San Diego, Worcester, Mass., Albuquerque, N.M.

Comment: Many believe this stage is the most mature. Others are not so sure.

Stage Five

Although it is not widely recognized, this fifth stage might be characterized as “all bets are off.” *Physician Practice Options* believes that this fifth stage con-

tains the following elements:

- Purchasers decide that HMOs don't deliver promised cost reductions, quality of care, or patient satisfaction. Instead, payers contract directly with organized systems of care and medical groups.
- Capitation fails to satisfy payers' demands for quality. Customer complaints rise and thus payers believe quality is eroded.
- Large staff-model HMOs begin to lose market share to smaller more nimble IPAs with broad geographic coverage, lower premiums, and a better understanding of the local market.
- Physicians begin to consolidate into large groups to become the focal point for contracting, to subcontract with hospitals and specialists, and to re-emerge as the power center in the system because of their ability to cut costs across the entire spectrum of care.

Comment: One could argue that an example of this stage is Minneapolis, which is struggling to move beyond stage four. ☹

Dominate: Three Revolutions

commercial insurance plans, such as those offered by Blue Cross and Blue Shield.

These events led to the glorification of health care as a social good, to the expansion of academic health centers; to the founding and financing of the National Institutes of Health; to the growth of medical research and technology; to specialization as the ultimate goal of most physicians; to the flowering of the pharmaceutical industry; to Medicare and Medicaid legislation in 1966 based on cost-plus fee-for-service reimbursement; to the explosion in the use of such technologies as renal dialysis, coronary bypass, and organ transplants; to the establishment of the medical-industrial complex; and to uncontrolled rising health care costs.

3. Managed Care

This revolution is actually a counter-revolution, developed to counteract the effects of the “health care as a social

good” revolution. Managed care began in earnest in the mid-1970s, when corporate health care buyers realized that health care inflation of two to three times the rate of general inflation could not be sustained. Paul Ellwood, M.D., who founded InterStudy, a managed care research organization in Minneapolis, and who later founded the Jackson Hole Group, and the Foundation for Accountability, in Jackson Hole, Wyo., helped persuade President Nixon and Congress of the advantages of HMOs in 1972. Hence the HMO Act was passed, giving managed care a jump start. These organizations, and their fee-for-service variants, PPOs, did not flourish until the late 1970s. By that time, the idea of independent practice associations (IPAs) had caught on, particularly in California, and managed care was on its way to becoming mainstream medicine.

By the early 1990s, American businesses discovered that health care was their

greatest expense, and after 1991, industry embraced managed care as the “one sure way to control health care costs.” After the Clinton plan collapsed late in 1994, payers intensified their efforts to switch to managed care.

Repeatedly in the 1970s and 1980s, Walter McClure, a colleague of Ellwood's and one of the authors of the managed competition theory of health care reform, which Clinton adopted, would warn businesses about health care costs. He believed payers would revolt. “Someday, ladies and gentlemen,” he would tell medical audiences, “the Barbarians will be at the gates. Payers are now at the gates, and they are beating them down, looking for still lower costs, a more rational system, and more value—in terms of better outcomes, better health, and more patient satisfaction—for their employees.”

By now, of course, we all know, McClure was right. ☹

Organization Options in the Emerging Health Market

A Conversation with Peter Grant, JD, PhD

To talk with Peter Grant, an authority on restructuring health care, is like trying to harness Niagara Falls. The former head of the Society for Healthcare Attorneys, Grant unleashes a torrent of information about national trends in health care, market dynamics, and deals struck among health care organizations seeking to position themselves for the future.

The current pace and scope of health care restructuring is extraordinary and pervasive, Grant says. As an example, he cites his hometown, 60 miles outside of Fort Worth. During a recent visit, he worked with the Harris Hospital System and played a central role in organizing a 2,000-physician IPA. What he saw was the rapid formation of partially integrated medical groups, which have doctors under contract and which contract with hospitals and health plans but are not part of the hospitals or health plans.

These medical groups assume all financial risk and capitate all services. These partially integrated entities include multi-specialty IPAs and capitated specialty groups, such as oncologists, ophthalmologists, and cardiologists.

The slow development of staff and dedicated group-model HMOs with salaried physicians surprises him, he says. In fact, many such organizations, including FHP Inc., the Group Health Cooperative of Puget Sound, and Kaiser Permanente, are facing stagnating growth, declining market share, and difficulties adjusting to rapidly changing conditions, he says.

This stagnation among staff- and group-model HMOs and the explosive growth of IPA-model and point-of-service (POS) plans has surprised many observers. An influential opinion-making group, The Advisory Board Co., in Washington, an association of service companies, has recanted its earlier predic-

tion that partially integrated physician organizations—often referred to as IPAs—were formed and managed too loosely to have a significant impact on the market and thus would fail. Apparently, these authoritative pundits were transfixed by structural efficiencies and vertical integration and forgot the market appeal of widely distributed outlets, convenient locations, and hometown physicians, Grant says.

What Grant sees in the market is the proliferation of IPAs that arrange for professional services through independent contracts with solo practitioners and small group practices. Often, a core PCP group is linked by a management service organization (MSO), which manages the business functions of the IPA and the group practice. The Mullikin Medical Group was the first group practice to establish an affiliated IPA. Typically, IPAs are composed of physicians in the community, are close to the market, and thus can quickly negotiate discounts with hospitals and other health plans. These characteristics have helped to fuel the explosive growth of IPAs.

About market trends today, Grant makes the following points:

1. Health care is delivered locally and rigid models cannot simply be transplanted from one area to another. If you do, “you may throw a party to which no one will come,” he explains.

2. Since health care is delivered locally, some markets, such as those in the East, are dominated by hospitals. In the East, the hospitals have the organization, the management expertise, and the capital. In other markets, large group practices and IPAs dominate.

3. Although experts say primary care is poised to flourish, Grant points out that many managed care markets have had



Peter Grant

A health care lawyer, Peter Grant, J.D., Ph.D., is a native of Stephenville, Texas, and a graduate of the University of Texas law school. He earned his doctorate from the Harvard Business School, and wrote his thesis on, “The Struggle for Control of California’s Healthcare Marketplace.” As a lawyer, he has been involved in a number of health care corporate reorganizations in California, including several involving independent practice associations, or IPA-model HMOs. At one time, Grant worked with Philip Lee, M.D., currently an undersecretary in the U.S. Department of Health and Human

Services, at the Palo Alto Clinic, where Grant came to recognize California as an unusual model for medical care delivery. His law firm, Davis Wright Tremaine, in San Francisco, has 300 lawyers, including 60 who specialize in health care, and 11 offices. Among his current clients are the Harvard Community Health Plan, the Prudential Insurance Co. of America and its management service organization (MSO). He also is working with health care clients in Atlanta, Memphis, and Fort Worth.

extraordinary growth in groups of specialists willing to accept capitation. Since Americans demand specialists, they cannot—and should not—be dismissed. Moreover, specialists will continue to mobilize to survive.

4. On the question of whether independent physicians should affiliate with hospitals, HMOs, or practice management firms, or seek acquisition by a third party, Grant does not have a single answer. Physicians today recognize that they must be part of larger organizations and they must consolidate, but the question of affiliation versus selling is an emotional one at the core of each physician's belief in professionalism and autonomy. As such, the answer is a personal one.

Affiliation Options

Physicians seeking to affiliate can do so with one of three players: local or regional hospitals, health plans, or proprietary physician management companies. Hospitals have been criticized for seeking only to fill beds, for being dominated by specialists, and for failing in some places to manage group practices. There are elements of truth to these criticisms, Grant says. But hospitals also are reservoirs of capital, have strong reasons to invest in doctors because physicians represent their life's blood in the form of patient referrals, and they are rooted in their communities. With proper leadership, hospitals can be dynamic and effective if management perceives them to be capable of transforming themselves from a traditional hospital structure into an MSO, in which the hospital and the community's doctors are partners in providing care, he explains.

The trouble with health plans is that they are in danger if they don't lock up primary care networks. Yet this move is difficult because primary care physicians

often don't have a sense of ownership and need incentives to be productive as salaried employees. Also, integrated health organizations that own health plans, facilities, and physicians have had flat enrollment, declining profit, and have been unable to organize quickly to reduce costs and thus offer lower premiums.

to-earnings ratios and if margins shrink? When these ratios and margins shrink, as they surely will, the only way to reward investors will be to divert funds away from doctors' salaries. Still, these companies, which are, in essence, proprietary MSOs, have plenty of room for consolidation. Physician management companies cur-

What happens, Grant asks, if margins shrink and if today's Wall Street darlings, physician practice management companies, cannot sustain their high price-to-earnings ratios? When these ratios and margins shrink, as they surely will, the only way to reward investors will be to divert funds away from doctors' salaries.

Many staff-model HMOs, like academic health centers, have an excess capacity in beds and specialists and are undergoing radical restructuring, cutting specialist staff members, acquiring primary care practices, and creating MSOs in order to attract PCPs and primary care practices.

Grant has mixed feelings about proprietary physician practice management companies, the current darlings of Wall Street investors and venture capitalists. It is true, he says, that these companies can bring capital to the market for physicians, and that they can implement needed management, marketing, and information systems for physician practices. Also, they can increase the net profit of physician practices. But what happens, he asks, if these companies cannot sustain their high price-

to-earnings ratios and if margins shrink? When these ratios and margins shrink, as they surely will, the only way to reward investors will be to divert funds away from doctors' salaries. Still, these companies, which are, in essence, proprietary MSOs, have plenty of room for consolidation. Physician management companies currently control only 5% of the \$200 billion physician industry market. Given public capital, they could move quickly, and plenty of capital is available, Grant says. Venture capitalists have \$5.5 billion to spend and they are moving much of that money out of biotechnology and into health services. At the same time, tax-exempt group models, such as the Mayo Clinic and the Cleveland Clinic, are hamstrung by regulations and thus limited in their investment options. For example, such organizations have rules that say no more than 20% of the membership of the boards of directors can be medical doctors.

In the end, the choices for doctors are many. The determinations will be made on local market trends and personal decisions. ©

Competition Among Managed Care Plans Squeezes Doctors' Salaries

The salaries of primary care physicians (PCPs) in managed care settings were higher than that of PCPs in non-managed care practices, according to a report on the 1995 Physicians Compensation Survey by the Health Care Consulting Practice of Ernst & Young, LLP. But while PCPs' earnings in managed care continued to be higher than that of their counterparts in non-managed care settings, the gap between the two narrowed in the two years that E&Y has done the survey, E&Y said.

and then pass on those savings to client customers rather than pass on the savings in the form of higher salaries, explained Heather Ladden, an E&Y consultant who was the survey coordinator.

PCPs in practices that derive more than 50% of their revenue from managed care earned slightly more last year than their counterparts in practices that derive less than 50% of revenue from managed care contracts, according to the survey report. The difference in median income

non-managed care practices increased dramatically from 1994," Rodeghero said. In 1994, the average income of specialists in non-managed care settings was \$132,000, and in 1995, it was \$162,000. The median pay in managed care settings for specialists in 1995 was \$147,000, E&Y said.

"Specialists still earn more than PCPs, including family medicine, internal medicine, pediatrics, and OB/GYN, even in primarily managed care practices," Rodeghero says. Surgical specialists were the best paid among all doctors, earning \$174,900 in median annual salary, survey results show.

The E&Y survey data confirm preliminary salary data from the AMA. At press time, the AMA was still reviewing the figures from an annual survey of doctors' salaries. But preliminary results show that for the first time in the 14 years that the AMA has been collecting such data, doctors' salaries declined. The median pay of all doctors dropped by 3.8% from \$156,000 in 1993 to \$150,000 in 1994, the AMA survey results show. In the two previous years, the median income had risen. In 1993 it rose 2%, and in 1992, it rose 7.9%, the AMA says. In an article on the survey,

The New York Times attributed the drop in income to the spread of managed care.

Other Findings

Among other findings from the E&Y survey were the following:

- The average earnings for PCPs in HMOs were \$128,100. But high performers can earn as much as \$200,000 including base pay and incentives and bonuses, E&Y said. HMOs were linking physician incentives to the results of teams of physicians or departments.

Median Total Annual Cash Compensation

(In thousands)

	Group practices	HMOs	Hospitals	IHS	<50% MC	>50% MC
PCPs	\$118.0	\$128.1	\$120.0	\$124.9	\$120.0	\$124.3
Medical specialists	154.1	165.0	140.0	163.1	161.5	147.1
Surgical specialists	200.0	174.8	205.0	228.2	219.3	174.9
Procedural specialists	193.0	164.4	170.0	201.5	194.0	166.2

Key:

Group practice: Free-standing group practice

HMO: Staff-model in which doctors are employed, or group-model in which doctors are under contract.

Hospital: Free-standing hospital

IHS: Integrated health system or physician-hospital organization

<50% MC: Health plan deriving less than 50% of its gross revenue from managed care contracts.

>50% MC: Health plan deriving more than 50% of its gross revenue from managed care contract.

The gap narrowed because the salaries of PCPs in managed health plans declined.

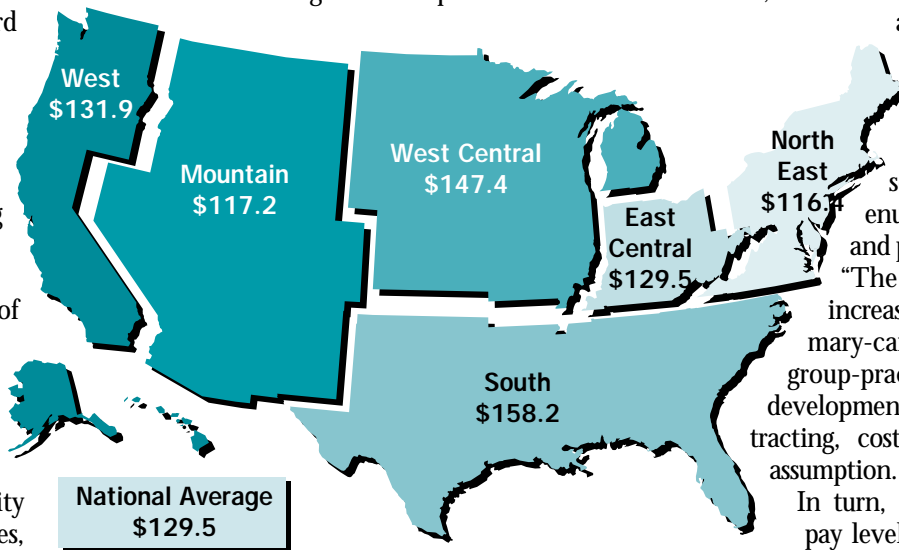
"The decrease in earnings of primary care physicians in predominantly managed care practices may be due to improved productivity and cost containment programs," said James A. Rodeghero, national practice leader for E&Y's physicians' compensation services, in Los Angeles. In the face of stiff competition from doctors and other health plans, managed care plans are forced to improve productivity and contain costs

was \$124,300 in 1995 versus \$120,000, E&Y said, and may be due to a strategy among managed health plans to foster the growth of primary care. Under this strategy, managed health plans have been paying PCPs more over the last few years than they had in the past.

While paying PCPs more, managed health plans have been paying specialists about the same or less. "While the average income of specialists in managed care practices remained constant or showed slight decreases, earnings of specialists in

Moreover, HMOs increasingly are basing physician pay on performance in such areas as patient satisfaction and quality, and on the size of the physician panel.

- Group practices are moving away from strategies that base doctors' income on practice revenue. Instead, groups are using more complex plans that base pay on salary plus performance factors, such as quality indicators and patient satisfaction. "As group practices' managed care revenue increases, traditional income distribution plans fail to measure and reward the appropriate practice behaviors," Rodeghero said.
- Increasingly, hospitals and integrated health systems are implementing plans that link salaries and incentive rewards for doctors. "As the amount of managed care revenue increases, the organizations can change the performance-linked incentive measures from physician productivity to managed care objectives, such as quality and patient satisfaction," Rodeghero said.



Source: 1995 Physicians Compensation Survey, Ernst & Young, LLP, Los Angeles.

tices. This movement is changing the professional and employment status of many doctors.

These trends are occurring as the overall economics of health care are being realigned, E&Y said. "The underlying risk management model is shifting from the cost-plus indemnity model to risk sharing agreements, cost management incentives, and capitated reimbursement. While the presumed advantages of managed reimbursement rather than indemnity payment have not all been realized—for example, cost savings under capitation are not uni-

movement into group practices," said the E&Y report on the survey.

"More and more physicians find themselves in group practices or in some form of affiliated or integrated practice model," the report said. "Solo practitioners are becoming rare as they increasingly become integrated through independent practice arrangements, physician-hospital organizations, and management service organizations."

At the same time, the report said, large staff-model HMOs have not come to dominate, as some observers had predicted years ago. "In fact, one large regional HMO is divesting its staff-model organization to allow the physicians to provide services (and gain revenue) from a broader patient and plan base," the report said. "The net result is a rapid increase in the formation of primary-care and multi-specialty group-practice models and the development of critical mass for contracting, cost management, and risk assumption."

In turn, these shifts are affecting pay levels in the various markets, the ability of plans to pay for physician labor, and the physician's role and value in integrated delivery systems, the report said.

versal—the shift to managed reimbursement and risk sharing seems irreversible."

Risk is shifting from insurers and other large payers to local and regional health plans, and even to medical groups and to individual physicians, E&Y said. This movement creates opportunities for doctors to participate in the profitability of the more efficient delivery systems. "This opportunity to participate in risk management at the physician and group level is creating challenges and opportunities, and is one factor in physicians' increasing

Survey Data

The survey data are effective as of April 1995 and are from 10,500 physicians, 2,600 allied health providers, and 600 physician administrators nationwide. Some 90 health care organizations participated in the survey, providing data on more than 40 medical specialties and 12 allied health providers. For a copy of the 44-page survey report, call Janel Patterson at E&Y in New York, at 212/773-2154. ☎

Two Trends

Two important trends are reshaping physician practices and, at the same time, are affecting earnings and pay plans, E&Y said. Those trends are

1. The movement toward integrated delivery systems and to develop more efficient delivery systems. These movements are changing the fundamental economics under which doctors practice.
2. The movement toward group prac-

Health Plan Costs Show the Effect of Managed Care

The cost of health care rose last year at the lowest rate of increase in 10 years, says KPMG Peat Marwick, benefit consultants in Montvale, N.J. KPMG, accountants and consultants, have surveyed employers for five years on the cost of health care. In its fifth annual survey, Health Benefits in 1995, KPMG surveyed 1,037 employers nationwide. Its

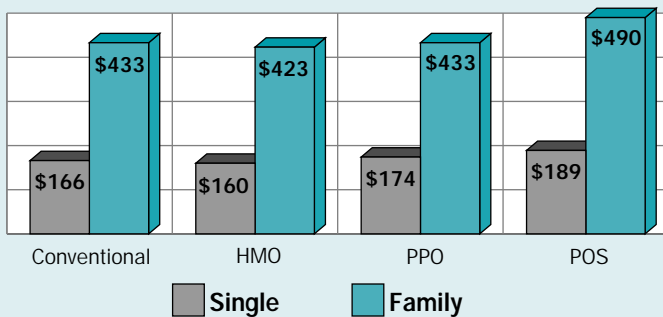
report said that the 2.1% increase in costs is lower than the 3.2% overall rate of inflation and lower than the 4.6% rate of medical inflation.

The results mean that health care providers and health plans have effectively squeezed costs out of the system, largely by introducing managed care plans widely. The 1995 results were the

third straight year of single-digit health plan premium increases. The accompanying charts show average premium costs, the growth of point of service (POS) plans, and enrollment trends since 1992.

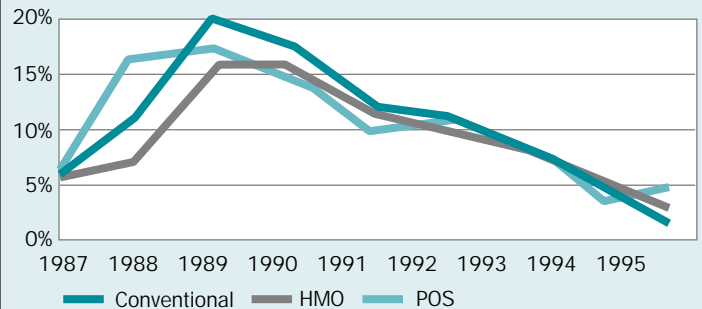
For a copy of the survey, call Derek Liston, KPMG, San Francisco, 415/951-7802. ©

Average Monthly Premium Cost for Single and Family Coverage



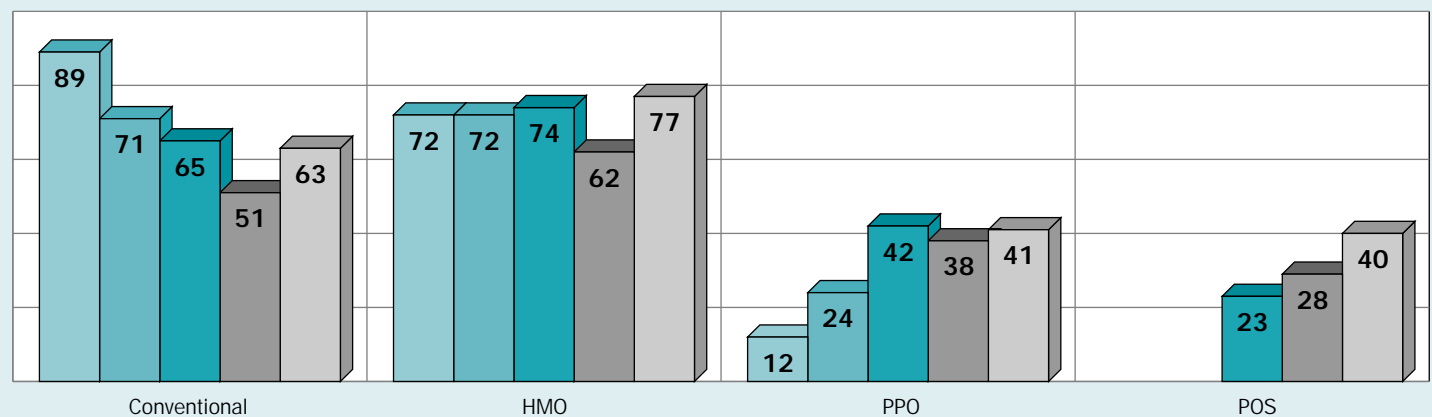
Source: KPMG Survey of Employer Sponsored Health Benefits, 1995

Premium Increases for Conventional, HMO, and POS Plans—1987 to 1995 (Percentage increase)



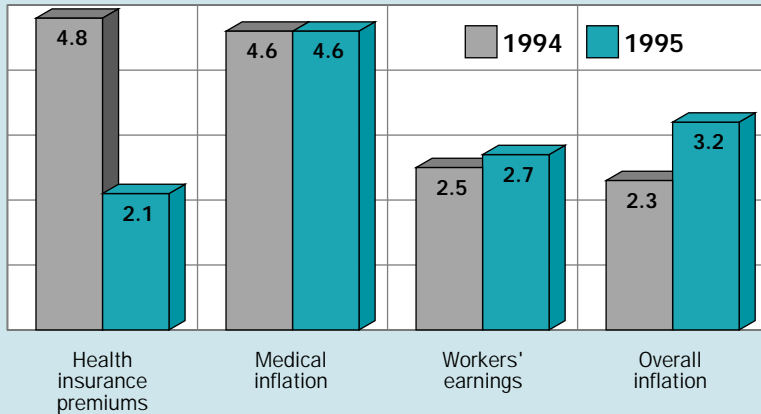
Source: KPMG Survey of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1992; 1991 HIAA Surveys of Employers, 1990; 1989; 1988; 1987

Health Plan Offerings by Plan Type—1988 to 1995 (Percentage of respondents)



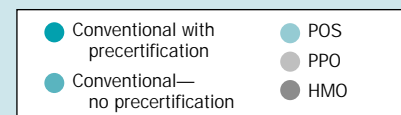
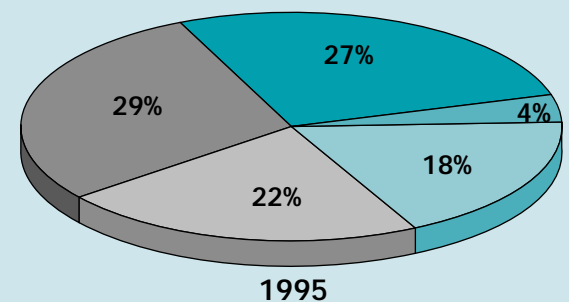
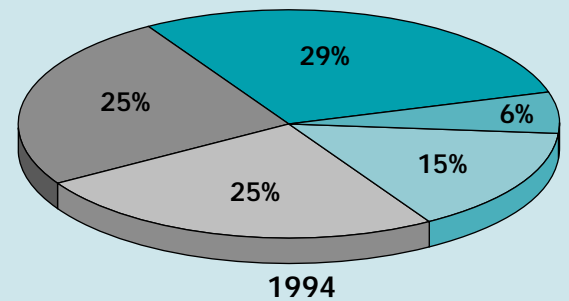
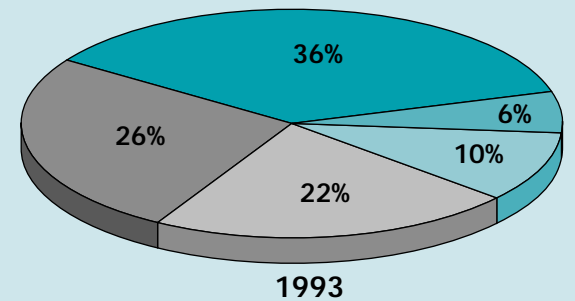
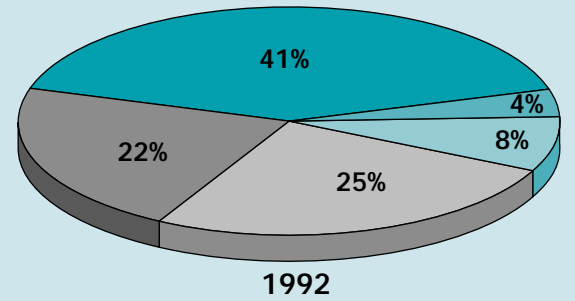
Source: KPMG Survey of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1991; HIAA Survey 747 Firms, 1988
 Note: Data on POS plan offerings are not available from the 1988 and 1991 surveys.

Increases in Health Insurance Premiums Compared With Other Indicators—1994 to 1995



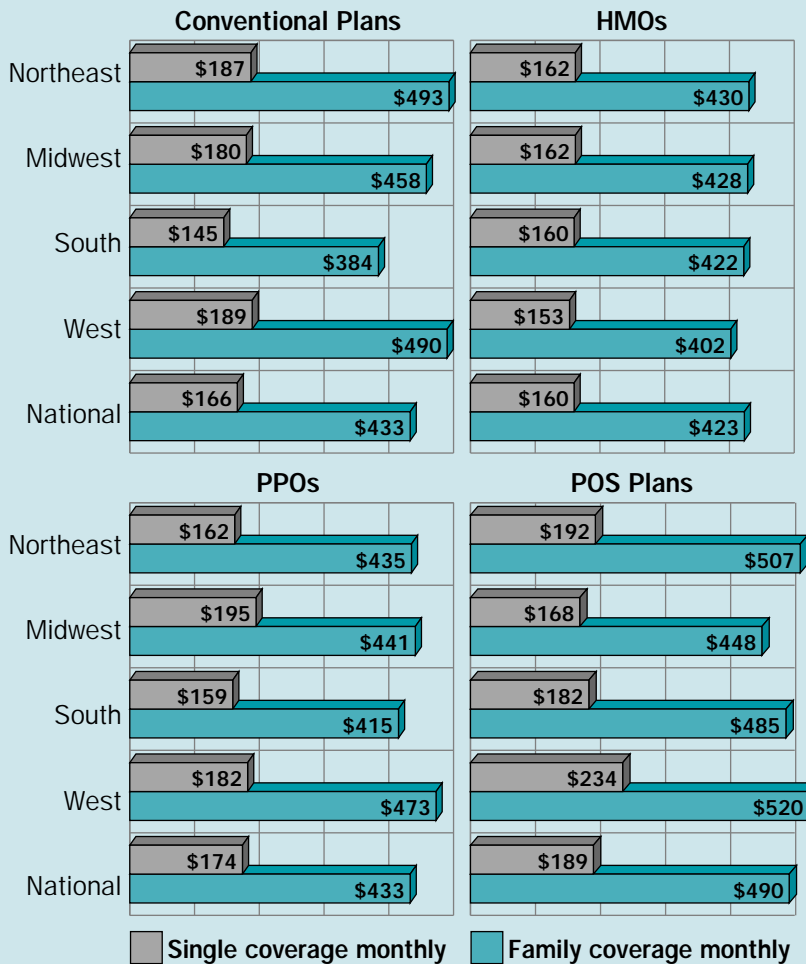
Source: KPMG Survey of Employer Sponsored Health Benefits, 1995; 1994; Bureau of Labor Statistics

Health Plan Enrollment—1992 to 1995



Source: KPMG Survey of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1992

Monthly Premiums in Conventional, HMO, PPO, and POS Plans, by Region



Source: KPMG Peat Marwick Survey of Employer Sponsored Health Benefits, 1995

The Realities of Capitation

The moderator of a recent conference on managed care advised the audience in this way: "Please take your Prozac now. And keep taking it because you're going to need it."

The audience was depressed by the news that success in medicine in the future will require that doctors do all of the following:

- Form or join large groups;
- Have access to significant capital;
- Minimize financial risk;
- Prove that they can perform as high quality, cost effective practitioners; and
- Deliver a comprehensive set of services at a budget price.

Open-ended, individualistic, traditional fee-for-service medicine can't compete on these counts. Only large organizations of physicians have the capacity to compete in the new marketplace.

The Spread of Capitation

In its publication, *Capitation I: The New American Medicine*, the Advisory Board Co., in Washington, an association of service companies, projects that 50% of U.S. citizens will be covered under capitated systems by 2005. Today, only about 6% of Americans are in capitated plans. Saying

will be good for the rest of the nation."

In its observation on the economics of capitation, the Advisory Board's Governance Committee said, "Health costs and health prices are in absolute decline in progressive capitated markets. The end of this nightmare of inflation rides on the backs of specialists." The committee could have added that hospitals also will suffer.

Why The Dark Future?

Why this dark future for specialists and hospitals? If a capitated system is deemed equitable, rational, effective, efficient, and acceptable to patients, payers will embrace it. Under a capitated system, hospitals and specialists will become cost centers. In cost centers, expenses—which in this case include doctors and hospitals' revenue—must be minimized. Moreover, payers recognize that hospitals and specialists are the most expensive parts of our health care system. Therefore, they are aiming to cut costs in these areas specifically. As a result of such cuts, some observers predict that 30% to 50% of specialists and hospital beds will be unnecessary in the future.

Under capitation, four new incentives are designed specifically to reduce hospitaliza-

visits, specialty referrals, and inpatient days.

4. Utilization drops, often overnight. Decreases in utilization of medical services of 15% to 60% are not uncommon.

Message in a Nutshell

The message in all of these trends is this: Managed care, integrated systems, and reimbursement by capitation are coming. Therefore, all doctors should get ready. It is apparent that some three to seven integrated systems will dominate heavily populated areas, such as Southern California; states, such as Minnesota; and regions, such as New England. These systems often capture as much as 80% of the market, leaving the remainder or less for indemnity plans. Most cities of 500,000 or more will have two to three large integrated systems.

These systems will offer a capitation option, will place hospitals and physicians at risk, will pay most physicians a salary, will select or retain physicians on the basis of cost-effective performance, will subdivide health care spending into well-defined areas of inpatient and outpatient care, and will reverse the current incentives to pay specialists for procedures and to fill hospital beds. In addition, these systems will aim to hospitalize fewer than 60 patients per 1,000 population versus more than 300 patients per 1,000 population under unmanaged utilization.

The reason for this change, in critics' eyes, is that the current system is irrational. The most expensive physicians are specialists. They represent some 67% of all American physicians and are paid more when they do more procedures. Lacking comparative data on outcomes (which are the results of care compared with that for other specialists), these specialists operate in an information vacuum. Their practice patterns tend to maximize their income, and much of their work is done in hospitals. Nevertheless, the overall health of most Americans is not significantly improved, and inflation in health care continues.

To make the system more rational and to

Some observers predict that 30% to 50% of specialists and hospital beds will be unnecessary in the future.

these systems will reduce costs and improve quality, the board predicts that the capitation systems of large California group practices will move quickly from west to east. The result will be a substantial surplus in the number of specialists and hospital beds.

There are those observers, however, who have never quite accepted the notion that what happens in California will sweep the nation. For one, Uwe Reinhardt, a professor of economics at Princeton University, has said, "Tell me in the year 1999 that costs are still down and I'll believe it. It's premature to say the California model is working and

tion rates and specialty use:

1. Insurers place doctors and hospitals at risk. Insurers have agreed to pay providers a fixed sum for each person covered under the plan regardless of the costs incurred. In some markets, the fixed sum is as low as \$60 per month.
2. Under such arrangements, doctors and hospitals pocket the profits that are left—if any—after care is delivered. They are rewarded for less care in the form of year-end bonuses or risk pools.
3. Physicians practice a new brand of medicine. Doctors are forced to reduce office

contain costs, critics assert that we must reverse the incentives. In other words, we must place health plans on a budget for all medical services, punish plans financially if they exceed the budget, force hospitals and physicians to look at the total costs of care across the system, and develop strategies for doing the right things at the right time for the right reasons in the right places. Appropriate and accountable care become the watchwords.

Historically, at least in California, capitation can save 30% on specialty services and 60% on hospital costs by reversing the incentives to reward specialists and fill beds.

Furthermore, the logic of capitation can be attractive to payers and providers. Payers favor it because the financial risk of care is shifted to providers. Many primary care providers see advantages to it because they can allocate costs by expense category over the entire spectrum of care, rather than managing the one small part they have handled under indemnity plans. By systematically managing costs in each category, doctors can increase predictability, decrease variability, and thus are more likely to stay within budget.

Options for Specialists

For specialists, the issue of capitation is more difficult. Capitation is threatening financially because revenue could fall by 30% to 40% compared with indemnity plan revenue. The options for specialists are:

- Do nothing;
 - Merge with other practices to contract with capitated care groups;
 - Join or be bought out by a hospital-driven organization with the potential capacity to win capitated contracts;
 - Form or join a physician-driven organization, such as an independent practice association (IPA), an HMO, or a physician-equity organization capable of winning capitated contracts;
 - Go to work for a large multi-specialty group with the necessary administrative skills to manage in a capitated system;
 - Become part of a vertically integrated health system with a strong primary care base and the ability to negotiate capitated contracts;
 - Retire; or sell your practice
- In reviewing the options, remember there

is strength in numbers. Those groups that thrive will be large organizations that can:

- Do disciplined utilization review;
- Operate in an outpatient environment;
- Have the requisite administrative skills to market the practice effectively and to administer claims;
- Have sufficient capital to build substantial information systems, and
- Have salaried specialists.

Plans that have salaried physicians are attractive to payers dealing with capitated

offer capitated care are becoming increasingly attractive to payers. These systems offer costs that are 30% to 40% lower and more predictable.

Since the incentives are in place to save money by using primary care physicians more and specialists less and to keep patients out of hospitals, capitation would result in a surplus of specialists and plunging hospital occupancy.

Whether capitation California style will spread east remains to be seen. Capitation

Payers dealing with capitated systems prefer salaried physicians because, unlike doctors in indemnity systems, salaried physicians have no economic incentive to do more. Instead, they have incentives to be efficient.

systems, because unlike doctors in indemnity systems, salaried physicians have no economic incentive to do more. Rather, because they operate under a budget, they have incentives to be efficient.

In addition, many practices and organizations exist that are unlikely to win capitated contracts with significant numbers of covered lives. These practices and organizations include those that are:

- Solo practices devoted to primary care;
- Solo practices devoted to specialist care;
- Specialty-dominated organizations without tight utilization review;
- Any academic institution with a large specialty base; and
- A hospital-driven system with too many specialists.

Conversely, those practices or organizations that are well positioned to win contracts for large numbers of covered lives are:

- Large primary care group practices;
- Primary care-dominated IPAs;
- Large multi-specialty groups with a bias toward primary care; and
- Vertically integrated systems with a strong primary care base.

Conclusion

As power shifts from providers to payers, and as markets shift to reduce costs and to improve quality, integrated systems that can

depends on large primary-care dominated practices, and few of these groups exist outside of California. So far capitation has thrived in those regions with large group practices and high costs. But solo practices can be converted into IPAs, and corporations can create or acquire large groups. Given incentives to survive and the needed capital, doctors will band together quickly.

Among physicians, many are skeptical about capitation. These skeptics doubt that low costs and high quality are compatible. They say that health plans cannot measure quality or efficacy, that productivity of physicians will drop as they become salaried, that patients will be under served, that care will be rationed in capitated systems, and that relying exclusively on outpatient primary care will destroy academic medical centers and specialty hospitals. Moreover, skeptics maintain that specialists reflect the excellence of American medicine and should be considered our pride rather than our Achilles heel.

In the end, the question that is being asked is this: Will payers trust a system dedicated to coming in under budget to the profit of its practitioners or will they trust physicians who profit from doing what they consider best for patients, even if it costs more? ☺

Physician Practice Management: Just What the Doctor Ordered

By Brooks G. O'Neil

As health care undergoes radical change, the general pattern is aggregation and integration. One key driver of change, managed care, has grown rapidly as a result of concerns about the cost and quality of care. We expect continued rapid enrollment growth in managed care plans for the rest of the decade. In particular, growth is occurring in regions of the country that are under-penetrated, for example, the South. Also under-penetrated are some selected niche markets, such as Medicare, Medicaid, and workers' compensation. In these markets, doctors have enormous opportunities to improve quality and to reduce cost through managed care.

We also expect consolidation to continue among managed care plans. There are 562 HMOs in the United States, according to InterStudy, an HMO research organization in Minneapolis. We expect this number to shrink during the rest of the decade as there are significant economies of scale in this component of the system. We believe United HealthCare's recent acquisition of MetraHealth is a catalyst for an acceleration of consolidation activity in this business. United HealthCare has created a platform to offer managed care in 90 markets nationwide. Other sophisticated HMOs will recognize the need to remain competitive with United by expanding the geographic scope of their operations.

The growth of managed care and consolidation in health care have created important challenges and opportunities for physicians. The challenges are to practice ever higher quality medicine and to deliver it at an ever lower cost. In addition, there are challenges to maintain clinical autonomy while managing the

complexities of multiple payers with innumerable payment schemes.

The opportunities are to take advantage of the changing environment to capture a growing share of the market and to uncover ways to increase personal wealth in the process. The keys to capturing market share are to increase in scale and sophistication. Many physicians need to affiliate with a partner who brings business management talent, managed care expertise, information systems, and capital.

The opportunity to increase personal wealth (as opposed to watching W-2s shrink relentlessly) relates both to income enhancement (or preservation) and translating current income into substantial long-term capital gains. The need for income preservation in man-


aged care is obvious. What is less clear, but we believe true, is that in many cases physician income has been enhanced by affiliating with a well-managed physician practice management firm.

The benefits of capital gains relate to the multiple effect and to the potential to reduce income tax liability. The stock market multiple dramatically amplifies the effect of income for publicly traded companies. This effect is not possible in private practice. The proposed reduction in long-term capital gains tax rates will compel many professionals to convert current income to capital gains. Doing so can save the tax differential that can be 20% or more between the two forms of income.

The stock market's reception to physician practice management companies has been strong this year. The mean appreciation for the 19 public companies we track has been 53% in the last 12

months. Seven have appreciated more than 95%, led by the 250% achieved by Orthodontic Centers of America Inc., Ponte Vedra Beach, Fla., which provides management and consulting services to orthodontic practices. We expect volatility in the shares of these young, fast-growing companies, but we believe many are poised for exceptional long-term performance.

The market for physician services is large and growing. It is strategically critical to all aspects of the \$1 trillion health care services market. As HMOs force spending away from costly inpatient settings, an increasing share of the overall dollars will be controlled directly by physicians through capitation. Yet, the market remains highly fragmented as physicians have been, by far, the slowest of the three major components of the health care market (insurers, hospitals, and physicians) to organize.

We believe the market potential for physician management companies is comfortably in excess of \$200 billion. Currently, only a small fraction of the potential market is being addressed by these companies. Therefore, we remain enthusiastic about the outlook for this emerging niche. As health care evolves, physicians must adapt to deliver high quality, affordable health care to their patients and to prosper from the opportunities available in the market place today. 



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For a copy of the 100-page report, "Physician Practice Management—Just What The Doctor Ordered," contact:

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Fax: 612/342-6360

Two Harvard Doctors Criticize Managed Care Incentives

Two Harvard University medical professors known for their criticism of health care have sharply criticized U.S. Healthcare, in Blue Bell, Pa., for the financial incentives of managed care and the requirement that doctors not discuss these incentives with patients.

David Himmelstein, M.D., and Steffie Woolhandler, M.D., said in an editorial in the *New England Journal of Medicine* (Dec. 21) that the 2.4 million member health plan in the Northeast spends only 74.4% of revenue on medical care and \$1 million per day goes to profit. "One secret to this success is a payment formula that binds pri-

mary care physician's interests to the firm's," Himmelstein and Woolhandler wrote. "The base capitation payment barely covers office overhead. An internist with 1,500 of the plan's patients might take home more than \$150,000 from bonuses and incentives, or nearly nothing. Although some of the bonuses and penalties target quality, most reward limiting care and boosting the HMO's image and enrollment." Bonuses are based on how well doctors keep patients out of the hospital and how well they limit referrals to specialists, Himmelstein and Woolhandler wrote.

In addition to the editorial,

Himmelstein criticized U.S. Healthcare and other HMOs at recent medical conferences and on Nightline on ABC. In an article in *The Philadelphia Inquirer*, Himmelstein said he did not think U.S. Healthcare was "any worse than many other plans." On Dec. 1, he was notified that he was dropped by U.S. Healthcare.

U.S. Healthcare's Corporate Medical Director Neil Schlackman, M.D., called the editorial extremely biased and filled with incorrect information, said *The Inquirer*. U.S. Healthcare provides incentives to PCPs largely based on how many immunizations they give,

whether they provide mammograms and measure patient satisfaction. Schlackman told *The Inquirer*. U.S. Healthcare is widely respected for its extensive data collection system, which it says it uses to measure and monitor the quality of care it delivers.

Comment: HMOs are deadly serious, highly competitive for-profit business enterprises that will do what it takes to make and protect profits, as Himmelstein learned, even though he was raising an issue that needs to be addressed in health care. As is usual when an HMO "deselects" a doctor from its physician panel, U.S. Healthcare gave no cause. ☹

California Hospital Struggles in a Mature Managed Care Market

Good Samaritan Health System's new top executive plans to cut about 300 jobs out of 3,800 this year to save money, according to an article in the *San Jose Mercury News*. The job cuts and other cost-cutting measures are designed to save \$39 million. Good Samaritan lost \$43 million for the year that ended June 30 and was purchased by Columbia/HCA Healthcare Corp., the nation's largest for-profit hospital chain, in a deal that closed Dec. 31, the newspaper said. The second biggest provider of health care in Santa Clara County behind Kaiser Foundation Health Plan, Good Samaritan owns three hospitals, Good Samaritan and San Jose Medical Center in San Jose, and South Valley Hospital in Gilroy, plus a satellite facility known as Mission Oaks in Los Gatos.

Comment: In the mature California managed care market, hospitals are near the bottom of the economic food chain. As such, they can lose a lot of money quickly, in this case \$43 million, especially if they antagonize those at the top of the food chain, primary-care dominated independent practice associations. Hospitals are no longer the center of the health care universe, and, as cost centers, can become marginal almost overnight. ☹

Florida Doctors Raising Funds to Start Two HMOs

More than 800 physicians in Dade, Broward, and Palm Beach counties have kicked in \$1.5 million to launch a doctor-run HMO in South Florida, according to an article in *The Miami Herald*. Some \$30 million more is needed to start the HMO by next summer, the newspaper said.

The doctors want to sell 18,500 shares of stock at \$3,500 each to raise \$64.5 million, the newspaper said. The efforts is being led by Primus Health Care Corp., in Aventura, Fla.

Another effort to start an HMO in Florida also is led by doctors. The Florida Medical Association, the Florida Independent Physicians Association, and the Florida Osteopathic Medical Association want to form the Doctors' Health Plan, the newspaper said.

Comment: If you can't beat 'em, own 'em. That's the new attitude of physicians toward HMOs. Of the nation's 562 HMOs, 39 have doctors as full or part-time owners. The fact that doctors are forming their own HMOs is compelling evidence of a shift among physicians toward managed care. Doctors everywhere are seeing the effect of managed care on their practices and their salaries. As a result, some doctors are wisely moving to become a part of the trend. ☹

Continued on page 16

Continued from page 15

PhyCor to Manage Guthrie Clinic

PhyCor Inc., a practice management firm in Nashville, Tenn., has entered into a series of agreements, including, among others, a five-year management agreement with the Guthrie Clinic, a 213-physician group in Sayre, Pa., according to Business Wire, a business news service. As is its practice, PhyCor also agreed to acquire certain assets of the clinic and agreed to enter into a long-term arrangement with Guthrie physicians at a future date, pending satisfaction of other conditions, Business Wire said.

PhyCor President and CEO Joseph C. Hutts said the clin-

ic is staffed by one of the most prestigious and respected medical groups in the country, the wire service said. Founded in 1910, it has a long history of providing multi-specialty health services and is heavily involved in medical education.

PhyCor operates 31 multi-specialty clinics with approximately 1,900 physicians in 20 states and manages independent practice associations with more than 5,000 physicians in 14 markets, Business Wire said.

Commentary: Among practice management firms, the oldest and largest is PhyCor. Its strategy is to acquire the non-real estate assets of large, multi-specialty clinics, preferably those with more than 100 physicians. Simultaneously, it enters

into long-term service contracts with those physicians. Recently PhyCor has emphasized management of independent practice

associations and tight control of hospital expenses. It has a reputation for treating physicians well. ☎

Another Market-Driven Shift: Medical Education

Recognizing that medical education is suffering, the Harvard Medical School and the Beth Israel Hospital in Boston will shift the emphasis of training doctors in hospitals to training them in clinics and homes in a new joint venture, *The Boston Globe* reported. Since patients are in hospitals for much shorter stays today, Harvard and Beth Israel officials believe it best to put medical students into doctors' offices, patients' homes, and clinics, the *Globe* said.

Commentary: No icons, not even Harvard, are spared cost pressures from managed care. As a result, even venerable institutions must turn themselves inside out to survive. Because it emphasizes lower costs, managed care once again shifts power from hospitals to physicians' offices. This shift puts academic medical centers on the bottom of the pyramid and PCPs on the top. ☎

PHYSICIAN PRACTICE OPTIONS

February 1996/Vol.1, No.1

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