The Ambulatory Care "Gold Rush?"

Michael A. Slubowski
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The California gold rush of 1849 parallels the current dramatic surge in the development of ambulatory care facilities by hospitals, physicians, and other entrepreneurs. In the California gold rush thousands of individuals put their entire holdings at risk for the prospect of striking gold and making a fortune; most came up empty-handed. Similarly, several health care organizations, for-profit companies, physicians, and others are placing huge stakes on the development of ambulatory care facilities with the prospect of huge returns on investment. However, if ambulatory care is not included as a component of a comprehensive vertical integration strategy, its chances for economic self-sufficiency become slim. The major types and trends of ambulatory care center development, rationale for development, and some of the economics of ambulatory care are described herein.

Ambulatory Care Defined

The concept of ambulatory care is a nebulous one. There is no set definition of the area of delivery because it reflects such a wide scope of different types of services. Examples of ambulatory care development in the system-owned sector are shown in Table 1. A variety of different services are involved when we include such examples as outpatient departments, clinics, wellness programs, the many forms of health maintenance organizations (HMOs), preferred provider organizations (PPOs), group practices, hospital emergency rooms, home care programs, same-day surgery centers, urgent care centers, surgi-centers, hospice programs, industrial health clinics, stress management programs, sportcare programs, and rehabilitation programs (1).

To focus discussions on some key ambulatory care diversification strategies, the ambulatory care businesses described in this paper involve a direct patient-physician encounter. Examples of growing ambulatory care businesses include group practices, urgent care centers, and surgi-centers.

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Group practices

Group practices of physicians have begun to grow. There were 15,485 medical groups with an average of 9.1 physicians per group in 1984, according to the most recent figures available from the American Medical Association (AMA). Group practices grew at an annual rate of 9.5% from 1980 to 1984, compared with 4.9% from 1975 to 1980 (3). Group practices come in various forms, including single-specialty and multispecialty, and have various sponsors, including physicians, hospitals, and HMOs. Most group practices include the following three attributes: 1) a single medical record is kept for each patient, and all services provided by the group practice are recorded in this record; 2) the physicians are located in a common site or sites with common administrative systems, i.e., appointments, billing, etc., and common ancillary services are also provided; and 3) income and expenses are pooled and redistributed based on a predetermined methodology.

Urgent care centers

Urgent care centers include two types of facilities: emergi-centers and primary care centers. Urgent care centers appeared in response to expensive hospital emergency department care and excessive waiting times for noncritical medical care. These emergency-focused centers promise fast, efficient, courteous

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health care services. The federal government has determined that it can no longer afford the escalating costs of the Medicare program. The dramatic changes made in the financial payment structure (diagnostic related groups [DRGs]) in the last few years will be expanded as our nation's aging population places increased demands on the financially strained trust funds. Many providers experiencing reduced profitability have reacted to reduced government revenues by shifting costs to nongovernmental payors. These payors have been quick to respond because they know the consequences of increasing premium rates. With these private payors moving to prospective payment systems and more controls, hospitals and physicians have had little choice but to respond to these financial incentives and change their behavior accordingly, including the use of more ambulatory care alternatives (7).

### Changing patterns of medical care

The focus of medical care has steadily shifted from inpatient to outpatient services. First, significant technological advancements have allowed many diagnostic tests and therapeutic regimens formerly requiring the patient's hospitalization to be safely conducted in an outpatient setting. Second, utilization review programs have reduced both the number of "social" admissions and length of hospital stay of nonacutely ill patients. Finally, changing consumer attitudes toward health care, including preferences for expedient, accessible ambulatory services over time-consuming inpatient alternatives, fuels the demand for ambulatory care (8).

### Physician surplus

Many areas of the country have a surplus of physicians, and there are no indications that the situation will soon change, according to the AMA's House of Delegates. The number of physicians will increase 39% to 696,000 in the year 2000 from 501,200 in 1983. There will be 259.9 physicians per 100,000 people in 1983 (3). With excess providers, excess facilities, and changing trends in utilization, one can begin to appreciate the competitive turmoil in the medical marketplace.

### Competitive developments in health care delivery

The advent of HMOs and PPOs and entry of proprietary chains into the health care delivery business further intensifies the competitive nature of the medical marketplace by "removing" patients from the "traditional" system of medical care.

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**Table 1**

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Total Number of Facilities 1984</th>
<th>Total Number of Facilities 1985</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery centers</td>
<td>47</td>
<td>79</td>
</tr>
<tr>
<td>Urgent care centers</td>
<td>150</td>
<td>151</td>
</tr>
<tr>
<td>Primary care centers</td>
<td>383</td>
<td>729</td>
</tr>
<tr>
<td>Diagnostic centers</td>
<td>33</td>
<td>61</td>
</tr>
<tr>
<td>Birthing centers</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Occupational health centers</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>Psychiatric clinics</td>
<td>55</td>
<td>67</td>
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<tr>
<td>Wellness centers</td>
<td>43</td>
<td>52</td>
</tr>
<tr>
<td>Health clubs</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Hospices</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Rehabilitation centers</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>Drug/alcoholism treatment centers</td>
<td>140</td>
<td>155</td>
</tr>
<tr>
<td>Home healthcare agencies</td>
<td>153</td>
<td>261</td>
</tr>
<tr>
<td>Durable medical equipment dealers</td>
<td>206</td>
<td>384</td>
</tr>
<tr>
<td>Pain clinics</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>86</td>
<td>181</td>
</tr>
<tr>
<td>Total</td>
<td>1,423</td>
<td>2,272</td>
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Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Centers</th>
</tr>
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<tbody>
<tr>
<td>1982</td>
<td>600</td>
</tr>
<tr>
<td>1983</td>
<td>1,200</td>
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<tr>
<td>1984</td>
<td>2,300</td>
</tr>
<tr>
<td>1985</td>
<td>3,000*</td>
</tr>
<tr>
<td>1990</td>
<td>5,500*</td>
</tr>
</tbody>
</table>

*Estimated.

(From the National Association for Ambulatory Care, 1985, FEC Factor II, Dallas, TX. National Association for Ambulatory Care. Reprinted with permission.)
Hospital, physician, and proprietary sponsors have individual reasons for accelerating their development of ambulatory care centers.

Hospitals—Hospitals are moving rapidly toward the day when outpatient services will generate most of their revenues. As much as 40% of hospital revenue comes from outpatient sources. The move to outpatient care is being fueled by several sources. To save money on hospital stays, Medicare requires that many procedures be performed on an outpatient basis. The list of Medicare-reimbursed outpatient procedures is being expanded. HMOs and other insurers also are mandating outpatient care. Consumers are demanding it because outpatient care is less expensive and quicker (5). In today's competitive environment, hospitals increasingly establish "feeder lines" for patients by buying up solo physician practices in surrounding localities or in potential satellite areas (9). In a Delphi study conducted by Arthur Anderson & Company (7), panelists predicted that during the next five years hospitals will face stiff competition from alternative providers including outpatient clinics, diagnostic centers, minor emergency centers, surgery centers, and home health agencies. These panelists expect inpatient and emergency room services to be less profitable for hospitals in 1990 than they are today. With the changes in payment incentives, ambulatory services are envisioned to become more profitable.

"Until recently, physicians earned far more per hour treating patients on an inpatient rather than an outpatient basis and by performing surgical and ancillary procedures as opposed to 'cognitive' procedures."

Physicians—The growth in group practices is partly attributable to changes in the health care marketplace. Buyers, such as insurance companies and prepaid plans, are negotiating with physicians on the basis of price. Although a single physician has no bargaining power, a group of physicians can negotiate effectively with buyers (3).

Proprietary organizations—Entrepreneurial entrants into the ambulatory care marketplace including physicians and large chain organizations such as Humana view ambulatory care "niche," particularly single-focus services such as urgent care centers and surgicenters, as extremely profitable business opportunities. For example, Humana's MedFirst facilities require a patient volume of 40 visits per day to "break even." The facilities are equipped to accommodate 90 visits a day. If revenue volumes and output were realized, a major profit center would result (10).

The Economics of Ambulatory Care
Changing financial incentives are resulting in an array of new offerings in the market by old and new players alike. This highly competitive, multisegmented market requires new skills and strategies. Vertical and horizontal integration must occur for health care providers to be competitive from both a service delivery and a pricing perspective. In conjunction with these new financial incentives, more services must be delivered outside the hospital setting. These alternative delivery sites must stress more convenient and less costly services. Integration of the financing of health care with the delivery system is how providers of care can remain economically self-sufficient under new incentive systems.

When ambulatory care is considered part of a vertically integrated host of products, it can contribute positively to the economic whole of the enterprise. When considered separately, however, ambulatory care programs generally have not provided a margin of revenues over expenses. The record of physicians, hospitals, and proprietary organizations in the development of segmented ambulatory care products without a linkage to a vertically integrated product line has not been good (see examples in Table 4).

The current method in which the majority of physicians' fees are reimbursed is far from perfect. The price structure has been subject to considerable criticism. Until recently, physicians earned far more per hour treating patients on an inpatient rather than an outpatient basis and by performing surgical and ancillary procedures as opposed to "cognitive" procedures (11). Furthermore, the usual-customary-reasonable (UCR) fee schedule...
approach is defective in that insurers using UCR often have substantial market shares, thus establishing market price. Another defect of most traditional physician payment schemes is that fee-for-service approaches do not integrate payment for physicians' services with other types of health care services (12).

Because of these defects in physician payment schemes, single-segmented businesses may suffer from insufficient revenues. For example, unless a primary care center overutilizes ancillary tests and/or generates abnormally high volumes per provider, it is difficult to make a primary care practice economically self-sufficient. In contrast, if these primary care centers were part of a vertically integrated organization that is capitated for hospital and physician services, they could certainly contribute positively to the economic viability of the integrated organization by serving as low-cost sites for primary and preventive services and as substitutes for more costly forms of care.

Medical Group Management Association statistics from the past few years indicate that net income available for distribution to physicians within a physician-owned group practice has hovered at approximately 41% of net collections (13). Physicians generally have been unwilling to retain earnings for their practice's growth and development at the expense of constraining their current personal incomes, which, when expressed as a percentage of net collections, are not growing. Thus, unless there are other related businesses which benefit from an integrated payment scheme (ie, capitated hospital services in addition to physician services), there are virtually no margins left after distribution to physicians from group practice earnings.

Humana, with over 250 MedFirst centers across the country, is still experiencing severe financial losses after five years of operation. Problems stem primarily from the centers being viewed as a single-market segment business and not as part of a vertical integration strategy. These centers have been unable to attain sufficient volumes in excess of break-even levels for several reasons:

A. The public still views these centers primarily as sites for episodic care. Despite assertions to the contrary, growth rates for the episodic care market have curtailed sharply from the 25% to 30% annual percentages predicted a few years ago. Thus, the market for episodic care is not as large as was previously imagined.

B. In markets where Humana owns hospitals, these ambulatory care centers represent a competitive threat to private physicians who admit their patients to Humana hospitals. As a result, Humana has been reluctant to promote the continuing primary care product line, which has limited its returns on these centers.

C. In markets where Humana owns hospitals and offers its wholly-owned insurance product (Humana Care Plus), Humana has not been able to offer price/service advantages to consumers for using its MedFirst facilities for fear of alienating private physicians who admit their patients to its hospitals.

Once Medicare certified surgicenters as medical providers, the centers were eligible for all-important health insurance reimbursement. However, this certification also convinced over 500 nonprofit hospitals to establish their own nonprofit, freestanding surgicenters either on the hospital site or at locations adjacent to the facility and local doctors' offices. These hospital-sponsored surgicenters are strong competitors to the business-owned surgicenters. Thus, the proprietary sector faces strong competition from the nongovernmental sector. The early, strong growth of 22% per year has moderated to 10% (4), and profit margins are slim due to prevalence of cost-based systems.

Payment schemes being contemplated for a more wholesale approach by the federal government include combined hospital and physician payments for inpatient services and capitation for hospital and medical services. If reductions are to occur in the growth of total real payments to the health care delivery system, utilization reductions must continue. Under capitation, the decision of where to cut is at least decentralized to a vertically integrated organization (12). Under a single ambulatory product segment approach, the issue of who receives the combined payment can have dire financial consequences for an individual provider; in a vertically integrated organization, the appropriate resources can be used to do the best job at the lowest cost.

The health care industry today recognizes that diversification is a survival strategy that must be given serious consideration. It is not surprising that ambulatory care projects are often among the first to be explored by providers confronted with increased competition for patients and with other pressures brought to bear as a result of DRGs and other cost-cutting incentives. Ambulatory care minimizes reliance on traditional sources of revenue without straying too far from the provider's established area of expertise. Providers who attempt to ensure successful diversification strategies for ambulatory care should do so in the context of a vertically integrated line of products, so that ambulatory care contributions can be realized in the context of total resource management in fixed fee and capitated payment systems.

References