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Issues Facing Group Practice in the 1990s

Bruce W. Steinhauer, MD*

Medical historians will be able to tell us later, but a variety of trends suggest that the creation of independent multispecialty group practices may reach its zenith in the late 1980s. If so, it occurs at a time when more medical school graduates aspire to careers in group practice than has been the case with any earlier generation of physicians (1).

Existing group practices are growing larger. Although results may be incomplete, the American Medical Association's 1984 report on medical groups in the United States suggests that the number of members in single specialty groups is growing rapidly. In 1969 these groups represented about 50% of all groups but increased to 70% by 1984. The multispecialty groups, on the other hand, are growing more in size rather than in number. The average size of a multispecialty group practice increased from 10 to 27 physicians between 1969 and 1984 (2). The formation of new group practices of any size is being accomplished with considerable difficulty, although there are some impressive exceptions (eg, the Oakhill Medical Group of Oakland, CA, formed under the inspired leadership of Dr Charles Dimmler).

Multispecialty group practice, as we now know it, flowered during the early decades of this century. The Mayo brothers inspired the creation of group practices in Minnesota as well as many other places, including Detroit's Henry Ford Hospital. As early as 1919, a group practice, the Ross-Loos Clinic of Los Angeles (3), became the vehicle for delivery of prepaid care. From those early days, multispecialty group practice has become a collection of physicians linked together in common locations by financial and programmatic interdependency. Groups employ common medical records, share personnel, and develop an internal referral system, both formal and informal.

This essay explores some of the factors that may inhibit the growth of new multispecialty group practices and examines at least one trend that may stimulate the formation of new groups.

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Profitability

Because maintaining excellence and expanding programs in the medical field is capital intensive, and because borrowing capacity is at least partially related to profitability, the borderline profitability of group practices is a matter for concern. Some factors limiting profitability include organizational issues, labor costs, methods of reimbursement, necessary unprofitable programs, and restricted access.

Organizational issues

Many group practices, especially those organized as partnerships, have difficulty retaining earnings. The legal structure of these partnerships requires the excess revenues to be dispersed to the physicians annually. Some partnerships have associations with not-for-profit foundations to offset this problem.

Professional corporations, the most popular framework for a group practice, also have not traditionally retained much of their earnings to finance future development (4). Physicians most often choose to take as much as possible out of their group practices in the form of personal earnings.

Labor costs

Multispecialty group practices are fundamentally labor-intensive endeavors. Much of the work involves intensive one-on-one verbal and technical exchanges between workers and patients. Extensive and time-consuming telephone conversations occupy time and manpower. The immense variation in the circumstances of an individual illness works against optimal efficiency. These are some of the reasons why group practices have thus failed to benefit from economies of scale, at least as far as manpower is concerned.

Methods of reimbursement

Profits in the medical field are appearing in unexpected places, but not necessarily at the level of the group practice. In contrast, in the last few years many hospitals have been surprisingly profitable as the result of the diagnostic related group (DRG) reimbursement system. A west coast hospital chain explored the possibility of sharing those profits with physicians, but the General Accounting Office expressed grave concerns, at least as to methodology. Similarly, health maintenance organizations (HMOs), which account for a considerable percentage of group practice business, also must maintain operating margins.
One stimulus to vertical integration of the health care system is the difficulty in developing a rationale for the assignment of operating margins when one is trying to consider what the hospital should retain, what the physician should earn, and what operating margin is needed by the HMO (5). This may partially explain the initiative of the Mayo and Virginia Mason Clinics to bring their related hospitals under their wings.

Necessary unprofitable programs

Because of the relatively high overhead of the very large group practices and the necessarily unscientific areas in which it is distributed, these group practices do have some apparent loss leaders including primary care, internal medicine, pediatrics, and occupational medicine. Even when these primary services are assigned a proportion of the operating margin of an alternative delivery system they remain borderline financially. These programs can be economically sound only in the context of profits in a larger “system,” which includes tertiary care group practice and hospital profits.

Restricted access

As a corollary to their profitability problem, the organizational structure of group practices often precludes their use of the capital markets which are available to hospitals, such as tax-exempt bonds. This restriction can be a major inhibitor to new program development.

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Alternative Delivery Systems and Group Practices

The early health maintenance organizations were principally related to group practices, such as the Ross-Loos Group in southern California and the Permanente Medical Groups. Accordingly, as the HMO movement expanded it might have been expected that organized group practices would become important sponsors for alternative delivery systems. For a variety of reasons, however, this has not happened to any great extent. First, few group practices had the necessary capital base and managerial support systems. Second, group practices were not sufficiently widely dispersed geographically to become a major force for HMO development throughout the country. Only seven states account for approximately 40% of all group practices. Furthermore, group practices appear to form in areas which are already most doctor dense. Over 80% of groups and available positions for new physicians in these groups are located in metropolitan areas (2). Because hospitals and insurance companies have greater depth of management and ease of capital access in comparison to group practices, they have more alternative delivery systems. This has resulted in multispecialty groups becoming either joint sponsors or simply providers for alternative delivery systems.

The principal growth of many group practices has been in the alternative delivery system arena, but, for reasons previously noted, they do not realize that they may wind up vulnerable to HMO management. Several offsetting strategies have been employed. One of these strategies is for group practices to engage in the activities of a number of different HMOs. Although this maneuver provides some leverage, it may produce confusion from a marketing perspective and often requires expensive, duplicative management systems. For many group practices this issue is substantially unresolved, but the happiest solution appears to be joint sponsorship. When providers do not heavily influence HMO activities, operating margins may be used inappropriately.

Physician recruitment is another major issue in the interaction of alternative delivery systems with group practices. In the exclusively fee-for-service world of the past, group practices simply did not provide a speciality service until the right person came along. In an HMO it is difficult to synchronize physician recruitment and patient recruitment. Physician recruitment done under time pressure is not always in the best long-term interest of the group practice. Examples can be cited of group practices heavily dominated by prepayment activity whose staffs have been compromised by these timing issues. Quality physician recruitment requires a clear, advanced understanding with the HMO about the use of generated profit margins.

Physician Compensation

The issue of income distribution in group practice is increasingly complex. The tension in this area has been compounded by recent well-publicized examples of decreases in income for some group practice physicians. Compensation philosophies used by various group practices are numerous and stouthearted and defended (6). In general the largest group practices prefer a salary system. A complex system allows the rewarding of individuals for a variety of tasks which may include teaching, research, and a necessary but temporarily unprofitable technology. The system tends to affirm the authority of leadership people, which has particular importance in very large organizations. It has been compatible with high professional performance in such distinguished organizations as the Mayo and Cleveland Clinics. Among the very large group practices (over 400 physicians), only Henry Ford Hospital has departed from the straight salary approach. The disadvantage of the straight salary arrangement may be that it encourages passive-aggressive activity on the part of the physician group. Because many group practices were founded and dominated by surgeons, the apparent subsidization of nonsurgical activities by surgical departments was not as difficult as it has become in recent years. In many group practices nonsurgeons are now comprised up to 75% of the group, and it is increasingly difficult for surgeons to affect apparent losses by internists, pediatricians, and family practitioners. Part of the reason why nonsurgical cost centers in group practices do not appear to flourish is because they do not include some of the activities that relate to the group practice world.
Organization of the Group Practice

Consensus management is both possible and appropriate in very small multispecialty group practices and single specialty group practices. For most group practices, however, more complex organizational schemes are necessary for success and growth (7). According to David Ottensmeyer, formerly of the Lovelace Clinic, the key to success of a group practice is delegated authority. A group practice differs from a medical school in its internal power dynamics. In a successful medical school, some of the ancillary revenues available in private offices. Furthermore, the way in which group practices handle overhead works to the disadvantage of this type of cost center, and it is increasingly difficult to persuade younger members of group practices to subsidize the incomes of more senior colleagues. The notion that certain senior colleagues are “rainmakers” who are not required to justify their compensation by current revenue generation (a theory widely held in legal firms) has little credibility in the medical group practice world.

Middle-sized to large groups commonly relate compensation both to individual effort and to group success. The Lovelace Clinic in Albuquerque has made important strides in this regard. At one end of the spectrum, for some years the Marshfield Clinic in Wisconsin achieved relatively equal compensation for their various specialists; at the other end, the Scripps Clinic bases compensation largely on individual revenue generation. The issue has been made more complex by the advent of the alternative delivery system. In the managed care process it is by no means inherently obvious what physicians should earn relative to one another. Group practices that mix fee-for-service and prepaid activity have been particularly plagued by this issue. Market surveys are used increasingly to determine the information base for physician compensation. Always important for the development of an information system that will adequately support compensation decisions is a key requirement.

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Agenda for Group Practice for the 1990s

To survive in an increasingly difficult environment there are several strategies that now freestanding group practices should consider. These are not mutually exclusive.

1. Group practices must develop a philosophy of dedicating a proportion of retained earnings and return on investments to new programs. Such policy requires good management and sometimes reduced short-term earnings.

2. Group practices may find it advantageous to merge with other group practices as in the case of the Park Nicollet Clinic. This activity could be described as horizontal integration. This strategy does not reduce costs to any large extent; however, it does lead to more formidable organizations when dealing with the purchasers of health care.

3. Group practices may merge or associate with larger vertically integrated health care organizations. A pactsetter in this regard is the Lovelace Clinic which, while retaining some autonomy as a professional corporation, joined the Hospital Corporation of America. Similar trends have been observed in Michigan. For example, Associated Physicians, a prominent group practice headquartered in Taylor, MI, recently joined the Henry Ford Health Care Corporation family of organizations. They did so because they felt their size was not sufficient for vertical integration.

The reasons for these developments, already suggested, include: 1) need for borrowing capacity to meet capital needs, 2) need for adequate leverage with alternative delivery systems, 3) need to maintain physician earnings when operating margins are being diffused throughout the system, 4) preference of purchasers of health care services for vertical integration, 5) purchasing advantages, 6) need for joint planning, and 7) higher expense of appropriate technology.

The disadvantages of these arrangements are that the resulting organizations are often too matrix in nature, and physicians, who tend to be at the obsessive-compulsive end of the psychological spectrum, do not work comfortably in matrix organizations. They are much more comfortable with clear accountability and responsibility. It is also difficult to replace entrepreneurship with entrepreneurship, and it is probable that physicians with the most entrepreneurial characteristics will be lost with this type of organization. Another danger is the loss of “attention to the customers.” The single-purpose multi-
specialty group practices generally have been strong in this area because of the clear relationship between physician earnings and patient satisfaction. That relationship is less obvious in the more complex matrix organizations which appear to be evolving, for it is harder to assign responsibility for patient difficulties in these types of organizations.

A future solution that would appear to best maintain the values of the group practices with the best opportunity to deal with current economic realities is the formation of medical conglomerates, with group practices being distinct corporations within the larger entity. In the resulting organizations, physicians should play key roles not only in the group practice management but in the management of the conglomerate itself. A growing alternative to this scenario is the hiring of physicians by major private hospitals. Such organizations probably will not encourage authentic group practice because of the inherent power dynamics in that system, but instead will develop strong salaried clinical departments. Only if they maintain their priorities of integrated services and high patient satisfaction can group practices compete successfully against this latter arrangement.

References