Special Article

'Fried Chicken' Medicine: The Business of Primary Care

Gregory A. Culley, MD
Braintree, Massachusetts

The current environment of pressures for health care reform have created a renewed interest in primary health care delivery. In most health care reform scenarios, family physicians and other primary care doctors are the case managers for all health care delivery. At the same time, there are intense activities from investment banking firms, insurance companies, hospitals, and home health companies, directed toward the purchase of primary care practices and organizing primary care delivery systems. These organizations seek to profit either from ancillary services generated by primary care or from capitation for a population of managed-care patients.

Based on personal employment experiences with a for-profit hospital company, the author illustrates the difficulty in developing and managing primary care as a business and the inevitable conflict between management and primary care physicians.

The article has detailed advice for family physicians to aid them in carefully examining organizational culture, financial structuring, physician relations, and operational aspects of any for-profit or hospital primary care system before deciding to become part of it.

Key words. Marketing of health services; managed care programs; health care delivery; health care coalitions.
(*J Fam Pract 1994; 38:68-73*)

Primary health care has been discovered! The federal government, insurers, HMOs, media, and even business now believe that primary care, especially family medicine, must form the foundation for health care reform.[1-4] This strikes an ironic note with those of us who have devoted our lives to the practice of primary health care. After half a century of government support for specialty training and research rather than primary care, it should be no surprise that the United States has an acute shortage of generalist physicians. This low supply has created a new market demand for family physicians.

Throughout the United States, family physicians are being courted by health care delivery systems, including hospitals, insurance companies, HMOs, and new corporations formed for the purpose of creating new group practices. Family physicians are facing the decision of whether to retain their present autonomy and risk being left out of future health care plans that may dominate markets or to join a health care corporation.

The centerpiece of the current administration's health care reform bill is the concept of managed competition. It is also important to note that the concept of managed care or managed competition is present in the major Republican bill and in the two other bills before Congress for health care reform. In areas of the United States where there is intense competition through managed care, there are organized or integrated health care delivery systems that contract with insurance companies, HMOs, and directly with self-insured employers to accept a fixed capitation for health care. The Clinton administration proposes regional health alliances (also called health care purchasing cooperatives) that would negotiate with organized health care systems, such as hospitals, physicians, and other health care providers, to deliver health care for a fixed percentage of the premium or a capitation.

An integrated health care system's ability to manage capitation has been proven to depend on an adequate supply of primary care physicians, especially family phy-

Submitted, revised November 12, 1993.

Prior to joining Humana, the author was at the University of Louisville School of Medicine, where his primary appointment was in the Department of Family Medicine. For the past 8 years, he has been a consultant to hospitals and managed care and physician groups. Address correspondence and reprint requests to Gregory A. Culley, MD, Healthcare Connections, Ltd, 25 Braintree Hill Park, Suite 308, Braintree, MA 02184.

ISSN 0094-3509

sicians. In areas such as San Francisco and Minneapolis–St. Paul, Minnesota, primary care physicians either work directly for the health care organization or, in many cases, are owners of the health care organization. Under some of these models the primary care physician may receive capitation not only for providing primary care services but also for managing other health care services. Some of the practice groups receive capitation for all professional fees and outpatient diagnostics. This portion of the premium dollar is generally referred to as "medical risk." Other more highly organized physician groups and health care delivery systems take the full medical capitation, which includes hospital, home health care, and pharmacy as well as all professional and diagnostic services.

The success of organized health care systems in some areas, as well as impending health care reform legislation, has created a near "feeding frenzy" in the purchases of primary care practices in many American cities.[5–7] New corporations, funded by investment banking firms, hospitals, insurance companies, HMOs, and companies such as CareMark and PhyCor, have been busy buying primary care practices and forming integrated health care delivery systems.

The average family physician struggling with a high-overhead, revenue-driven, low-margin business might wonder why anyone would want to purchase a practice, but the businesses and hospitals that are buying primary care practices have both short-range and long-range strategies.

There is considerable money to be made from ancillary diagnostics and home health services, especially from intravenous (IV) infusion services (IV antibiotics, total parenteral nutrition, and IV chemotherapy). Many of the companies purchasing practices tie the primary care physicians to specific laboratories, diagnostic imaging centers, and home health and infusion services companies owned by the same corporation. Issues of self-referral and inappropriate utilization are rarely addressed under these arrangements.

The most important business strategy in managed primary care relates to the potential profits from the management of capitation. Many physicians see the risk shifting from the insurance companies to the physicians as a way for those companies to get out of the risk business. Physicians and businesses that see this as an opportunity realize that such arrangements can be profitable. However, to be profitable it is assumed that the primary care group is cost-effective, of high quality, able to generate patient loyalty, and equipped with data systems capable of tracking the costs of care.

A simple example illustrates the levels of profit that can be earned by such arrangements. Let us assume that in a group of five family physicians, each is given 3,000 members from an HMO to manage the members' medical risk (all professional fees and outpatient diagnostics). The capitation is actuarially determined at $40 per enrollee per month. The group then would receive $600,000 per month or $7,200,000 per year, from which it would have to pay all expenses and salaries, as well as manage the care that includes other physicians' professional charges and the outpatient diagnostics. A well-run, organized, cost-efficient primary care group that manages its patients carefully, has arrangements with cost-effective specialists, and carefully tracks expenditures can be expected to make a profit ranging from $1 to $5 per enrollee per month. A profit of $3 per enrollee per month would represent $540,000 for 1 year from this group's capitation. Reduction of hospital admissions, hospital days, and costs also generate profits on risk or capitation contracts.

Multiply this projection by thousands of primary care physicians in cities across the United States and it is obvious why the investment banking firms, insurance companies, hospitals, and other entrepreneurial corporations are anxious to buy practices or develop integrated systems. For a small investment, these enterprises can not only control the entry point for health care but also reap great profits.

The days of a practicing family physician independent of an organized system are probably numbered, but the marriage of capital and primary care is not necessarily a bad thing. The key question is, "With whom should I join in this new partnership?"

The MedFirst Story

The case of MedFirst represents an early entrepreneurial effort to organize primary care from a cottage industry into a business. MedFirst was not a completely integrated health system, nor was it involved in the management of capitation. Although Humana Inc has since split into two separate companies, one for managed care and one for hospitals, they undoubtedly have learned from the MedFirst experience and appear to be successful in both the managed care and hospital businesses.

In 1982, Humana Inc was a highly successful hospital company. It had grown from a company that originally managed nursing homes and had entered the hospital business in the late 1960s. Through increases and stock splits, a share of Humana Inc purchased in the early 1970s for approximately $8 had appreciated to over $1,200 by 1982.

In 1981, after some study, the senior management of Humana decided to begin the process of vertical

integration, which included the development of primary care operations known as MedFirst in major American cities. Although the original idea for the MedFirst extended-hour physician office was that of urgent care or minor emergency care centers, the concept evolved in early 1982 into one of continuity of care, family practice, or general primary care.

The offices were located in the suburbs, where there was a shortage of primary care physicians. They were open 12 hours a day, 365 days a year, and staffed by family physicians, general internists, and in some cases, pediatricians.

Original business plans were aggressive (one might say overly optimistic). The rate of growth was expected to exceed 40 patients a day within the first few months, with an average revenue of over $40 per patient visit.

Although some consideration had been given to developing an independent professional corporation owned by Humana and staffed by Humana physicians, the final model was based on a physician relationship that was, in effect, an "arm's-length" contract between the management company owned by Humana and the professional corporation owned by the independent physician. Between 1981 and the spring of 1985, the terms of this contract changed several times. Essentially, the contract stated that Humana Inc owned the facilities, employed the nonphysician staff, did all billing and collecting in the name of the professional corporation, and paid the professional corporation a percentage of collected receipts. While MedFirst was operational, the percentage of receipts paid to the professional corporation decreased a number of times with successive contract changes.

The original management staff of the Health Services Division of Humana Inc, the division responsible for the management of MedFirst, was drawn almost entirely from hospital operations: the executive vice president had been in charge of hospital reimbursement; the first director of operations had been a hospital administrator, and the marketing and finance directors also were from the hospital division. At first, there was no full-time medical director, but in early 1982, a prominent family practice physician who had been founder and chairman of the Department of Family Practice at the University of Louisville was hired as the medical director. He was responsible primarily for the shift from provision of urgent care to that of continuity of care based on the family practice model. I was the second physician hired, initially as the associate medical director. By June 1982, there were 18 MedFirst offices in six cities scattered from Salt Lake City, Utah, to Atlanta, Georgia. The period between June 1982 and May 1983 was one of rapid growth, resulting in 65 MedFirst offices in 23 cities and 12 states.

This stressful period of rapid growth involved intensive recruiting of physicians from professional corporations and private practice, initiating the complex logistics of marketing, development, and building, and the opening of primary care offices. Much of what happened during this time was experimental, but the expectations of the original business plan remained intact. The initial television advertising campaign was carried out in Atlanta, Georgia, in January 1983 when there were only 10 MedFirst offices. Following this TV blitz, patient volumes increased 25% to 100% in many Atlanta offices.

The growth rate at most of the offices, however, never reached expectations. By March 1983, it was obvious that the original goals of rapid growth in patient volumes and an average revenue per visit of over $40 were unrealistic. Some offices produced extremely high revenue per visit because they were staffed by physicians with experience in emergency rooms or by internists who tended to order large numbers of laboratory tests and radiographs, but for most offices, the average revenue per visit was well under $40. Failure to meet the target of volume and per-visit revenue for each visit increased the stress on the senior division leadership. At one point I was told, "Go out there and tell those doctors to order more x-ray and laboratory tests." When I replied that I could not do this, I was then asked to go out and find out why there was such a wide variation in physician practice patterns. I found what has already been described by others[8]: family physicians and pediatricians are cost-effective, do not order large number of ancillary tests, and do not refer or admit as many patients as do internists.

Corporate pressure on the senior management of MedFirst increased greatly. In May 1983, all division employees were called together and told that the division was being scaled back and that we would now be managing the present 65 MedFirst offices for the next year to see if we could make them work. In this open forum, the executive vice president stood before the group and read a list of those who would be staying with the division and those who would not. Those not staying were told that every effort would be made to try to find other positions for them within the company. Company wags referred to this period as "the reign of terror." I preferred "the corporate grand mal convulsion."

After the division staff was cut almost in half, a new vice president was brought in to manage the MedFirst project. From May 1983 until September 1984, there was little growth in existing or new markets. With intensive efforts to understand what makes primary care work, the determinants of volume and revenue factors were better understood. During this period and the earlier "reign of terror," the contracts of numerous physician professional corporations were terminated. (Contracts

could be terminated on 60 days' notice at the end of 1 year.) Many of those terminated were perceived to be excellent physicians, but they simply could not meet the volume or revenue expectations.

A television advertising campaign was carried out in all the markets where there were enough offices to justify the expense. During that year of managing the existing offices, losses were expected, but the division was required to keep them within a budget. For the most part, volume and office expense expectations were met. The revenue-per-visit issue was solved by a computer system that automatically billed patients, allowing the physician little say in determining the patient's bill. As a result, the average per-visit revenue increased to over $50 per visit. By the spring of 1984, the division was considered a success. The budget was exceeded and the losses were less than expected. Plans were then made to expand operations to over 3000 MedFirst offices, with most major American cities targeted for development.

MedFirst division's senior management wished to expand using a franchise model in which a professional corporation or physician entrepreneur owns the primary care center, much as an individual franchises a restaurant as part of a large national chain. Because of the similarity, a former executive for Popeye's Fried Chicken in Louisiana was brought in to develop the franchising product.

After a brief study period, the senior management of Humana Inc decided not to adopt franchising because of Humana's general philosophy that they do not wish to manage any business they do not totally own. Although a disappointment to the senior management of the MedFirst division, it was decided that primary health care was a retail business, and that it was similar to fast-food operations. In the fall of 1984, division operations were turned over to the former "fried chicken" executive. He brought on board a number of others from the franchised fried chicken sector, including regional operational directors and managers. The new director of marketing also was recruited from the fried chicken industry, albeit in her case, Kentucky Fried Chicken.

Rapid growth occurred again in 1984 and 1985. Offices were acquired in Chicago and other cities, and operations were directed by individuals with experience in the retail food business. Operations manuals, protocols, policies, and methods adopted from the fast food industry were expanded and applied to primary care delivery (offices were referred to as "stores"). Once again, the contracts of physicians who were deemed uncooperative or who could not meet the new standards were not renewed and new physicians were brought in. The revenue-sharing contract changed several times, each time decreasing the percentage the professional corporation received.

From early 1985 through 1986, rapid growth combined with unmet volume and revenue expectations led to the decision by Humana's senior management to divest itself of the entire MedFirst system by 1987.

Lessons

The primary lesson of the MedFirst experience is that the corporate bottom line or business considerations can influence the practice of medicine. Both subtle and not-so-subtle pressures can be brought to bear upon the physician to alter practice styles. MedFirst represented fee-for-service abuses, which occur elsewhere as well.[9] Undoubtedly, the same abuses occur under capitated, integrated systems in which the profit motive discourages testing, referring patients, or hospitalizing patients.

Second, it is difficult to standardize physicians' practice patterns. Many of us have noted that organizing physicians is somewhat like herding cats. To expect physicians to behave in the manner of fast-food franchisees was never a realistic expectation. Physicians need to be equal partners in the development of the systems, procedures, and protocols for managing primary care centers.

Third, physician satisfaction is paramount to success. Physician-patient relationships are the basic product of primary care. Frequent changes of physician, lack of continuity, and physician dissatisfaction will not produce successful enterprises. To view the physician as an expendable commodity to be changed at will misses the point that patient loyalties are to physicians, not to a building or corporate logo.

The most important lesson is that primary health care delivery is a unique health care enterprise. People with extensive experience in hospital management, insurance companies, or retail business cannot necessarily translate that expertise into the management of primary care or family practice. Throughout my medical career, I have noted what I call the "ignorance/arrogance coefficient." Certainly, we can understand arrogance because many of us as physicians have been systematically and didactically taught to be arrogant. We also are able to accept ignorance, especially regarding medical knowledge. The combination of arrogance and ignorance is deadly. When health care executives or other business executives arrogantly assume they can manage an enterprise of which they are ignorant, the results will be disastrous.

On the other hand, there are a number of advantages of being in an organized group. The individual physicians will have more leverage in negotiations with managed care organizations. Further, the hassles of managing a private practice, including overhead expenses, person-

nel problems, billing, and accounts receivable, are often better managed by a health care corporation. Another advantage of joining an organized system with numerous managed care contracts is the 15% to 30% increase in income enjoyed by primary care physicians in these systems.

Large organizations have the resources to hire nurse practitioners, physician assistants, and other health care team members. These mid-level practitioners are essential in case management or the handling of a panel of capitated patients. Individual physicians often have trouble attracting or justifying the expense of mid-level health care practitioners.

Finally, data systems necessary to prove quality and cost are expensive. The management of a panel of patients requires sophisticated computer tracking systems. Individual physicians often cannot afford such systems, and therefore must rely on insurance company data to determine if the physician is successfully managing the capitation.

Areas of Concern

Most family physicians in urban areas will soon be approached either to join organized systems of health care delivery or to sell their practices. This decision should be based on a number of factors. Above all, each physician will have to weigh the importance of autonomy against the importance of maintaining job security and income stream. In highly developed managed care markets, the majority of patients are contracted to organized systems of health care delivery.

I offer three general categories of advice to any physician contemplating selling a practice or joining an organized system of primary care or health care delivery.

Organizational Culture and Financial Issues

Before agreeing to any price for selling their practice or joining one of these organizations, physicians must evaluate the organization's culture, values, and mission. Although these may be difficult to assess, experienced physicians who spend adequate time with the organization's executives and physicians before joining will be able to judge whether they are compatible. Do not listen to what corporations say in their marketing pitches—look at how the company is organized.

Ask to see the business plan of the corporation that shows how the company plans to profit and succeed. If you do not understand the business plan, ask your accountant and lawyer to go over it with you. If the company refuses to show you the business plan or the expectations for how revenue and profits are to be made, consider this a warning regarding future open disclosure and trust.

In examining the business plan, determine exactly how rapidly the primary care business is expected to grow and question if the growth expectations are realistic.

Will you be expected to refer patients to a specific diagnostic center, laboratory, imaging center, or infusion company?

If the revenue is to be generated on a managed-care risk basis, does the company already have arrangements with insurance companies, health alliances, self-funded employers, or HMOs?

What are the systems for managing care? Does the computer system provide adequate reports regarding flow of dollars to the specialists, ancillary care, and hospitals if that is included in the risk contract?

Even if the company is not yet publicly traded, how many shares are outstanding? How many shares are reserved for the physicians? How do physicians earn shares?

How well is the company capitalized? What is the status of the company's balance sheet?

What is the experience of the top nonphysician managers? Have they run primary care practices? Have they had direct experience in the primary care business?

Although more difficult to determine, what is the attitude of the senior nonphysician executives toward physicians? If possible, before signing with any corporation, insurance company, or hospital group, be certain to talk with the physicians who are now associated with the operation. Ask them specific questions about their relationship with the corporation, the logistics of the primary care office, compensation, lifestyle, and whether they would do it again. If possible, also speak with physicians who are no longer with that operation to find out why they left and what problems they experienced.

Physician Leadership and Physician Group Issues

I consider this the most important factor in the equation. Are there physicians on the board of the corporation? Is there a full-time physician leader on the senior management team or policy-making body of the corporation? Has that physician practiced primary care for a significant period? Do physicians have a voice in the daily running of the office or does the statement "Doctor, you run the practice and we'll manage it" express the policy? The "two-headed monster," in which the physician is expected to "just practice" and a nonphysician to totally manage the practice, rarely works.

Is there an organized physician group? How is it run?

Physician Compensation

What is the rationale for purchasing your practice? How is the formula determined? How long are you expected to stay? What percentage of your patients are expected to follow you? If joining without a practice, is there a sign-on bonus? Are entry salary levels competitive?

What factors are involved in physician compensation and bonuses? What level of productivity (patients per hour or per day) is expected? Are salary increases and bonuses based on ancillary utilization and revenue generation? meeting capitation targets? quality issues including patient satisfaction? subjective assessment of the medical director or business executives?

Two important things to remember: compensation schemes that rely heavily on either the generation of fee-for-service through ancillaries or the reduction of medical costs through intensive management of capitation have the potential for abuse; and primary care practice has capital value, but there are different methods for determining value.

Generally speaking, these include the hard assets such as the building, equipment, and the accounts receivable purchased. Further, most companies that buy practices pay a percentage of the 1-year gross or net of that practice. Based on the author's experience, this percentage varies from 25% to 40% of annual gross.

Conclusions

Family physicians and primary care physicians, our day has come. We are now wanted. We are no longer second-class citizens, and we will be courted by all manner of businesses, insurance companies, HMOs, hospitals, and other physician groups. Family practice and primary care undoubtedly will be practiced through organized systems of health care delivery. Economies of scale and negotiating leverage will dictate this change. Family physicians will have to merge their practices or join organized corporations. My advice is to carefully examine the organization's culture and its financial, organizational, and physician relations before selling a practice or joining any organized system of health care delivery. The primary care business is not the hospital business nor is it the fried chicken business.

We should not forget that physician services are the product. The introduction of capital and business practices into primary health care delivery should be welcomed only if physicians are *true partners* in the enterprise.

References

1. Schroeder SA, Sandy LG. Specialty distribution of U.S. physicians—the invisible driver of health care costs. N Engl J Med 1993; 328:961–3.
2. Grumbach K, Fry J. Managing primary care in the United States and in the United Kingdom. N Engl J Med 1993; 328:940–5.
3. Budette PP. Achieving a uniform federal primary care policy—opportunities presented by National Health Care Reform. JAMA 1993; 269:498–501.
4. Wright RA. Community-oriented primary care: the cornerstone of health care reform. JAMA 1993; 269:2544–7.
5. Palmeri C. Buying doctors. Forbes 1993 Jun 7:45.
6. McDonald's methods come to medicine as chains acquired physician practices. Wall Street Journal 1993 Aug 24:B1.
7. Corporations are buying physician practices. New York Times 1993 Sep 1:1.
8. Lane W, Sincich T. Selection of cost-effective primary care case managers. Medical Interface 1992; Oct:90–3.
9. Bock RS. Pressure to keep prices high at a walk-in clinic. N Engl J Med 1988; 319:785–7.