Competition through physician-managed care: the case for capitated multispecialty group practices

STANLEY J. TILLINGHAST
Alliance for Medical Systems Transformation, Davis, CA, USA

Abstract

The dominant managed care model in the USA is the individual practice association (IPA), in which physicians in separate practices contract with a health plan. One alternative model, the capitated multispecialty group practice (CMGP), has some distinct advantages: (i) the best randomized trial comparing a health management organization (HMO) with indemnity insurance showed equivalent health outcomes for a prepaid group-practice model HMO, with about a 40% saving in cost, mostly from lower hospital utilization. There is no comparable evidence for IPA-style HMO’s; (ii) most managed care plans control costs through ‘gatekeeper’ primary care physicians or capitated payment. Strong financial disincentives to care, applied to small practices, lead to a significant risk of withholding needed care. Large capitated groups diffuse the risk among hundreds or thousands of physicians; (iii) small practices also lack the financial resources and expertise to develop information systems, continuous quality improvement programs, and other means of improving efficiency. Larger groups can integrate specialty and primary care, laboratory, pharmacy, information technology and other services, to improve quality and cost-effectiveness, while maintaining physician control of the process; (iv) in urban California, HMO enrollment in six large capitated groups increased by 91% from 1990 to 1994. Hospital utilization for these groups was less than half the USA average; (v) because it is self-insured, the CMGP could contract directly with purchasers, eliminating the need for the insurance intermediary.

The CMGP offers an ethical, effective alternative that maintains the primacy of the physician in health care: physician-managed care.

Keywords: capitated payment, health maintenance organization, managed care, physician ethics, prepaid group practice, quality of care

Health care reform is taking place in many industrialized countries around the world [1–5]. Although the historical development, cultures and political and economic environments differ, there is widespread belief in the need to introduce competition among providers, and perhaps of third-party payers [6]. Where there are or have been national health systems, as in the UK [7] and the former Soviet Union [3], there are attempts to form market-based systems intended to bring the efficiency of the marketplace to increase consumer choice and encourage better resource allocation.

At the same time, a revolution in the measurement and improvement of quality of care is taking place in the international medical community. This is driven partly by the evolution of evidence-based medicine and partly by the recognition of the potential for applying continuous quality improvement techniques and outcomes-based quality measures to health care. Perhaps the most important force driving health care reform, however, is the demand for accountability of the health care system to the public and to purchasers of care. In the USA, this is primarily employers; in many western European nations the government is the primary purchaser of health care. If the quality of different health care providers can be measured and compared, it then becomes possible to assess, for the first time, the value received for resources spent. Consequently, there emerges the possibility of designing national health systems based on evidence of health outcomes achieved and cost-effectiveness of different organizational and financial models of care. The recent success in controlling health care costs through competitive managed-care systems in the USA [8], may lead to similar systems being contemplated in other countries [9].

Although managed care in various forms has existed for more than 50 years, the most radical and rapid changes have occurred since 1994, when the Clinton administration health

Address correspondence to Stanley J. Tillinghast, Executive Director, Alliance for Medical Systems Transformation, 2413 Rivendell Lane, Davis, CA 95616, USA. Tel: +1 530 753 3076. Fax: +1 530 753 3033. E-mail: sjtill@aol.com
Evidence comparing fee-for-service indemnity insurance with managed care

In the age of evidence-based medicine, one might expect that a national revolution in health care in the USA would be based on good scientific evidence that the new health care system is more cost-effective and of at least equivalent quality to the system it replaces. That is only partly true.

The Rand Health Insurance Experiment (RHIE), begun in the mid 1970s, remains the largest randomized controlled trial of the effects of health insurance type on costs and health outcomes, and the one with the longest follow-up. The study compared fee-for-service insurance with different levels of copayment (free, \( n = 304 \); pay, \( n = 571 \)), and a prepaid group practice, the Group Health Cooperative of Puget Sound (\( n = 798 \)). Compared with fee-for-service insurance, the prepaid group practice subjects experienced about 40% less hospital utilization, but with somewhat more outpatient visits, and greater use of preventive services. Both discretionary (elective) and non-discretionary (non-elective) hospitalization was reduced, reflecting an organizational practice style emphasizing more outpatient treatment [13]. For the groups as a whole, health outcomes were similar. However, for lower-income subjects who were initially ill, outcomes were worse in the prepaid group practice [14]. A plausible explanation by the authors was that low-income members may have more difficulty negotiating the organizational barriers to utilization which seem to be common in prepaid group practices [14].

A randomized trial of prepaid, capitated (\( n = 384 \)) care compared with fee-for-service insurance (\( n = 387 \)) for elderly Medicaid (USA and state-funded insurance for low-income people) recipients was carried out in Minnesota. Subjects randomized to the prepaid Medicaid group were able to self-select among seven different plans, representing a very heterogeneous group including a closed-panel health management organization (HMO), a network HMO, and five independent practice associations. After 1 year, no significant differences were seen in health outcomes for the two groups. Subjects in the prepaid group had significantly fewer physician visits [adjusted odds ratio = 0.46, 95% confidence interval (CI) = 0.29–0.74] and hospital admissions (adjusted odds ratio = 0.55, 95% CI = 0.32–0.94) [15]. From the standpoint of analyzing differences among prepaid health plans, the study is limited in the sample size, heterogeneity of plans and lack of randomization to plan (as noted, subjects selected themselves into one of seven plans). Lurie et al. performed another randomized trial of Medicaid patients diagnosed with chronic mental illness, with a 1-year follow-up period. This study also did not show any significant adverse effect of enrollment in the prepaid plan [16].

The best designed observational study comparing fee-for-service with HMO cost, utilization and outcomes was the Medical Outcomes Study (MOS); the MOS confirmed the RHIE finding of significantly lower hospital admission rates for HMO plans (26–37% fewer admissions than for indemnity plans) [17]. Thus the two largest and best designed studies comparing costs and outcomes between fee-for-service (with indemnity insurance) practice and HMOs demonstrate substantial cost savings due to decreased hospital utilization. The MOS appeared to confirm the poorer outcomes observed in the RHIE of poor, chronically ill patients treated in the HMO versus the fee-for-service setting [18]. Of particular note, in
both the MOS and RHIE the HMO patients were mostly enrolled in staff- or group-model HMOs.

Miller and Luft have reviewed the evidence comparing the performance of prepaid health plans (HMOs) and indemnity insurance, from 1980 to 1994. They excluded from their analysis the randomized trials mentioned above except for the RHIE, because the low income population served by the Medicaid program included in such studies was not representative of the general population in its use of medical care [19]. Other studies reviewed were observational studies, subject to substantial risk of selection bias as individuals self-select their insurance plan based on their perceived individual needs and values. The overall conclusions of this review were that HMOs had health outcomes that were roughly comparable with those of indemnity insurance plans; and that hospital utilization was lower in HMOs, due partly to fewer admissions, and partly to variable but generally lower length of stay. Miller and Luft did not find convincing evidence of the superiority of staff- or group-model HMOs over individual practice association (IPA)-model HMOs, but methodological problems with the definition of type of plan and the small number of observations limited the strength of this conclusion [19].

In summary:

- the best study comparing fee-for-service indemnity insurance with a managed care system used a prepaid group practice model, similar to the Kaiser Permanente Medical Care Program, as a comparison. Similar health outcomes were seen for the prepaid group practice subjects as a whole at about 40% less cost. However, low-income, ill members had worse outcomes than in fee-for-service practice. This may be attributable to non-financial barriers to access;
- there are no good studies that compare health outcomes and costs between IPA-type HMOs and either fee-for-service or prepaid group practice. Thus the HMO model with by far the largest enrollment in the USA has never been subjected to a well-designed experimental or observational trial of its effect on cost or outcomes. There is no good reason to believe that one can extrapolate from the RHIE to a much different model of managed care.

Why did the managed care revolution occur in the mid-1990s?

For historical reasons related largely to preferential tax treatment and union bargaining, employers are the purchasers of health care insurance for most Americans. With the exception of a few prepaid group practice health plans, until the 1970s most insurance was indemnity insurance-paid fee-for-service physician and hospital care. The federal HMO Act of 1973 provided grant and loan support to encourage the formation of HMOs, and also required employers to offer HMO plans as an alternative to traditional indemnity insurance coverage, if a federally qualified HMO was available in that geographical area. Despite this encouragement, the growth of HMOs, or what later became known as managed care, was quite slow. In addition, the form of HMO that became dominant was not the prepaid group model based on the Kaiser Permanente Medical Care Program, but the IPA model. IPAs were more popular for two reasons:

- most people already had some relationship with a private physician. The IPA could offer contracts to many or most of the physicians practicing in a given area, because the contracts were not exclusive. A given physician might have patients belonging to perhaps a dozen different IPA-type HMOs;
- because the IPA was simply a contractual arrangement between the insurance company, individual physicians, and one or more hospitals, it could be started easily with very little capital. Hence there was virtually no entry barrier to new IPA-type HMOs.

In the early 1990s, health care costs in the USA were increasing at twice the rate of inflation. Indemnity insurance, previously the most popular form of health insurance, had been priced out of the market by sharp rises in fee-for-service reimbursements. Much of the increase in health care costs was due to the rapid growth of expensive, high-technology medical care provided to an aging and demanding population that believed that more medical care was, in fact, better medical care. Physicians and patients were insulted from the costs of their decisions by employer- or government-paid insurance that paid the physician the ‘usual and customary’ fee – whatever the physician’s conscience would permit. The physician’s financial interests and the patient’s expectations were perfectly aligned to increase the use of the newest and most expensive care.

The employers, who usually paid either all of or the great majority of the cost of health insurance for their employees, had no way of comparing the quality of one health plan with that of another. In any case, there was an unlimited tax deduction for employee health insurance, so the employer was in effect only paying about half the cost of the insurance.

As health care became more expensive, it became more catastrophic to get sick without insurance; yet the cost of insurance was so high for individuals (who got no tax break for private health insurance) that 37 million Americans had no health insurance.

In this setting of exploding costs and lack of universal coverage, the Clinton administration introduced a health care reform proposal in 1993–1994. Initially regarded as likely to be enacted, political momentum for the proposal declined with claims that the cost would be greater than that originally estimated, and with concerns – stimulated partly by the insurance industry – about the impact of a `federal takeover’ of health care. In August 1994, a large coalition of employers in California [the Pacific Business Group on Health (PBGH)] announced that new health insurance premiums for the following year with no cost increase had been negotiated. The primary political impetus for the bill, control of health care cost escalation, was lost. On the day that this rate agreement was announced, the stocks of for-profit HMOs...
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on the New York Stock Exchange plummeted. When major restructuring of the health care system began occurring without government intervention in the midst of the debate over national health care reform, much of the support for major federal reform collapsed [21]. The market was finally starting to operate in health care.

1994: the revolution in managed care in California

Continuing for several years after 1994, the PBGH and other large purchasers in California such as the California Public Employees’ Retirement System (CalPERS) successfully negotiated either reductions in health care premiums for their members covered in managed care plans, or very small increases in premiums, which were less than the rate of inflation [11].

Subsequently, health care costs in the USA as a whole also slowed dramatically. In 1996, the rate of increase, 4.4%, was the lowest in four decades [22]. For 1998, there may be a larger increase in health care costs nationally, but large purchasers such as PBGH and CalPERS have succeeded in negotiating increases of only 1% [6]. PBGH also negotiated ‘pay for performance’ financial mechanisms to encourage health plans to adhere to quality of care guidelines developed by its Health Services Advisory Committee [20].

The next step in the drive for accountability of health plans to purchasers will be to adjust premiums for the risk of the insured populations. In the absence of risk adjustment, plans have a strong motivation to ‘cherry pick’ – to encourage lower utilizers to join the plan, and higher utilizers to avoid it. As will be discussed below, this motivation becomes even stronger when health plans are being monitored for health care outcomes: if low cardiovascular surgery mortality is an indicator of quality of care, hospitals and health plans may avoid operating on sicker patients to make their reports look better. For the market to work properly, health plans should be given a financial incentive to recruit and retain higher risk individuals. Although the methodology of risk adjustment is not yet completely developed, this will be an important part of making managed competition work [23].

The impact of practice type and physician payment mechanism on physician autonomy and ethical practice

Historically, most physicians in the USA have practiced in small practices, either solo practices or small groups of physicians in the same specialty. As indemnity insurance became unaffordable due to rapid escalation in health care costs, and as managed care has become more popular due its better ability to control costs, the small private practice is rapidly becoming an endangered species – at least in the parts of the USA where managed care has a high penetration, and where there is a surplus of physicians relative to the needs of a managed care system. The HMO contracts with primary care and specialty physicians can be terminated easily without showing cause. Particularly for specialists who are more in surplus than are primary physicians, a substantial part of their practice can disappear virtually overnight if they lose an HMO contract. This gives the solo practice or small practice physician very little negotiating power with HMOs; repeated reductions in payments are the usual result. Perhaps more important, the isolated physician is in a very poor position to serve as a strong advocate for the patients’ interests against a denial of service by an HMO, when the physician’s livelihood is dependent on the continuing goodwill of that HMO.

In an age of increasing complexity of medical practice, of strong pressures to reduce costs of health care delivery, and of the need to demonstrate quality of care, the small practice physician does not have the resources to invest in information systems or alternative forms of practice. Nor is the physician likely to have the expertise needed to evaluate, acquire, and implement new practice modes developed by others.

By contrast, larger medical groups of several hundred to several thousand physicians, which exist in urban areas of California, do have the resources necessary to institute new modes of practice, to develop information systems, and to implement systems for monitoring and improving quality of care. The larger groups are multispecialty groups, so that specialty expertise is more easily available, and potentially can be as efficient or even more efficient than primary physicians in providing care to patients with conditions that fall in their specialty. Particularly if the group physicians are salaried rather than paid on a fee-for-service basis, it may be advantageous to decrease rather than raise barriers to access to specialists. A phone call, a walk down the hall, or a ‘curbside consultation’ can be an effective and very efficient way of bringing the specialists expertise to the service of the patient, and to the educational benefit of the primary physician.

In addition to the organizational advantages of a larger group, the growth of capitation as a payment mechanism from the HMO to the physician adds substantial advantage to membership in a large group practice. Capitation payment means that a physician, or group of physicians, is paid a stipulated amount (‘per member per month’) to provide a defined set of services for the HMO’s members: this may be for primary care, for primary and specialty care together, or in some cases for all care including hospital care and out-of-area services (i.e. emergency care provided to insured individuals who were temporarily away from their usual site of care. ‘Stop-loss’ insurance – reinsurance purchased by a physician or group that indemnifies the practice for expenses above a certain high level – can protect a small practice against the risk of very high utilization (a heart transplant, say). However, the individual physician in a small practice still has a very strong financial incentive to
reduce utilization of specialty services, including surgery. To the extent that needed care may be withheld – and it is often difficult to judge what is needed and what is not – this strong financial incentive puts the physician in a position of conflict of interest with the needs of the patient.

In a large group practice, the capitation payment is spread among hundreds or thousands of physicians. The impact of a single medical decision for a given patient, therefore, is minimal. The physician is thus in a much more neutral situation: neither paid more for doing too much, nor paid more for doing too little. In many large groups physicians are salaried, although with some pay differential for 'productivity', such as caring for a large panel of patients. This strategy among many large group practices of engaging staff physicians on salary has been regarded as the least likely to lead to ethical compromise of the physician–patient relationship [24].

What has been the impact of the growth of managed care in California on physician practice? Robinson and Casalino have described the growth of six large medical groups in California between 1990 and 1994 [25]. HMO enrollment with capitated payment increased in these six groups by 91% from 1990 to 1994. Because these medical groups assume the risk for utilization of hospital care, they have a strong motivation to decrease hospital utilization, and this did indeed occur. Mean hospital days for non-Medicare (i.e. under 65 years of age) enrollees ranged from 120 to 149 hospital days per 1000 enrollees in 1994, compared with 232 for California as a whole and 297 for the USA in 1993. For Medicare enrollees (over the age of 65 years), comparable figures were 643–936 days per 1000 enrollees for the six groups, compared with 1337 for California and 1698 for the USA [25].

As Robinson and Casalino point out, large medical groups paid through capitation offer a potentially worthwhile alternative to the two extremes of physician employees in hospital-owned HMOs and subcontractor status in IPA-type HMOs. The physicians in the medical group take on for themselves all decisions regarding care provided, and assume the responsibility for controlling utilization. Rather than having to go to a non-physician HMO employee for prior authorization for hospital admission – typical with IPA-model HMOs – the prepaid group practice sets up its own rules for admission. Typically, because the physicians have no financial incentive to admit patients to the hospital, no prior authorization is required.

This system therefore permits the physician to retain the autonomy to practice as he or she sees fit, albeit within the constraints of a collaborative culture that encourages general cost-consciousness. The impact of a given medical decision on the physician's income is so diffuse that it is minimal, as long as the individual physician is paid by salary.

In sharp contrast, IPA-style HMOs often use a 'gate-keeper' system to constrain utilization of specialty services. Since specialists in fee-for-service practices often use expensive, high-technology services liberally, referral to a specialist is usually expensive for the HMO. The primary physician is therefore put in the position of controlling access to specialists: the patient cannot initiate an appointment with a specialist, but must be referred by the primary physician. Some portion of the primary physician's salary is withheld against the risk of utilization of specialty services and surgical procedures. In capitated systems, the risk for the physician in a small practice may be even greater: payment for referrals may come directly out of the primary physicians capitation payment. These strong financial incentives to avoid referral are rightly felt to constitute a conflict of interest [26]. The overall result of this system is greater reliance on primary physician care rather than specialty care; and with a strong motivation not to refer patients to specialists. These systems are now in widespread use, yet they are not based on any good evidence of the health outcomes associated with such a practice model. As noted previously, the only large-scale randomized trial of HMO versus fee-for-service care, the RHIE, enrolled HMO patients in a group-practice-model HMO with salaried physicians.

**Does the medical group need the health plan?**

We have now described a medical practice model consisting of a large, multispecialty medical group, paid under capitation. The capitation payment may include payment for hospital services, out-of-area services, and referral to physicians outside the group. In other words, the medical group is at risk for all medical expenses that might be incurred by a member of a health plan. The group will probably contract with one or more hospitals to provide care for its patients at a favorable rate. The medical group will put into place its own utilization management mechanisms. In order to establish its costs and negotiate its payment with the health plan, it will need its own accounting and actuarial expertise. Why, then does this medical group need an insurance company as an intermediary? Aside from regulatory requirements that are left over from the days of indemnity insurance, the only apparent reasons to need an insurance plan intermediary are for marketing purposes and for capital formation. Large employers like to be able to deal with a single health plan for its employees around the country, rather than contract with individual medical groups. However, there is no intrinsic reason (antitrust issues aside) not to form coalitions of medical groups, or even for medical groups to combine into a national organization for the purposes of marketing their health care services. Indeed several large companies have been formed that perform this function as well as other administrative functions for large numbers of physicians. These are physician management organizations (PMOs).

Raising capital is another important issue for health care organizations. For-profit health plans can raise money by selling shares; non-profit hospitals can sell bonds. Medical
groups have more difficulty raising capital. On the other hand, some of the large groups studied by Robinson and Casalino have sold their assets to outside investors, then lease them back. This reduces the capital needs of the group [25].

Can managed care lead to higher quality health care?

One important aspect of the ongoing health care revolution in the USA is the demand by purchasers, especially large employers, to ‘pay for performance’: they want to be able to compare the quality of health plans and providers along several dimensions, so that they can make better choices about the use of their funds for employees’ health insurance. This demand began with a few large national employers such as the Xerox Corporation, and was then picked up by the purchasing coalitions, and most importantly by the National Commission for Quality Assurance (NCQA) [27]. NCQA is the industry-funded organization that accredits HMOs. Encouraged by the large employers and by at least one large HMO, Kaiser Permanente, NCQA began developing a set of indicators that provides for the first time objective, valid, evidence-based indicators of health care processes and outcomes. Although still very limited in scope, this indicator set, called Health Plan and Employer Data and Information Set (HEDIS) is growing in capability.

Other organizations, such as the Joint Commission for Accreditation of Healthcare Organizations and the Foundation for Accountability, have developed or are developing sets of indicators to measure quality. Most recently, a Presidential commission recommended that a set of quality indicators be developed on a federal level to encourage health care organizations to compete on the basis of quality. These efforts, particularly NCQA’s HEDIS, have received substantial publicity in the national mass media, with articles rating the quality of HMOs, primarily according to the HEDIS ‘report card’.

Although these efforts to measure and compare quality of care show substantial promise, one must be cautious about overenthusiastic adoption and interpretation of these measures. However, a detailed description of these indicator sets is beyond the scope of this article. It may suffice to note that the first indicator sets emphasize adherence to evidence-based preventive services guidelines and other measures for which there is good scientific evidence of benefit. That is, of course, necessary otherwise we might be encouraging – even demanding – that all health plan members receive preventive screening or other care that will not really improve health. On the other hand, it is clear that these indicators have been adopted because: (i) everyone agrees on their importance; (ii) it is clear whether the procedure has been performed or not; and (iii) the denominator of the population in need is readily identified (e.g. all women aged 50–74 years need mammograms). Other indicators being developed will examine mortality after myocardial infarction, and other measures that attempt to assess the quality of acute care.

Unfortunately, much of what physicians do that makes them good physicians, particularly in the acute care setting, is difficult to quantify. While there is much enthusiastic support for developing and adopting such quality indicators, there is also a danger in focusing on what we can measure, as if only that were important. Once indicators are adopted and purchasers begin choosing health plans, hospitals, and physicians on the basis of good indicator scores, those scores will invariably improve: what gets measured gets done, or at least gets reported. Reliance on performance indicators is particularly worrisome when physicians face strong disincentives to utilization of care. Good performance scores should be regarded as a necessary but not sufficient measure of quality of care.

Necessary to the success of performance measures is the development of sophisticated medical information systems that are designed to collect essential clinical information in a standardized way. Development, or at least purchase, of such systems is likely to be very expensive, and therefore to require a large organization to have adequate capital to fund it. In addition to the advantage of size, larger organizations are more likely to incorporate subsystems of care, such as pharmacy and laboratory services, within the organization. This permits developing integrated information systems which can, for example, provide feedback to physicians and administrators on the cost-effective use of medications and laboratory tests.

Measuring quality is important. More important, however, is using that information to improve current practices, making them more scientific, more cost-effective, and more patient-friendly. Although not as capital-intensive as medical information systems, the process of continuous quality improvement (CQI) also benefits from an integrated service delivery system. For example, if we want to improve the management of high cholesterol, it is very helpful to have an integrated pharmacy, nurses and dietitians, specialty physicians with expertise in lipid management, an efficient and accurate chemistry laboratory, and a sophisticated computer system to track patient lipid measurements and feed them back to staff and patients. Such ‘best practice’ development probably occurs best in an organization of at least moderate size. Whether there is further economy of scale beyond a certain size is not yet clear. It does appear, however, that a system that is fairly integrated in its services, and with adequate resources and expertise to commit to such a task, is more likely to be successful in such efforts than is a small office practice.

If such efforts in CQI and re-engineering of medical practice do indeed show us the future of medical care, then that future is very likely to be in a fairly large multispecialty medical group. That group will have the financial incentive, through capitated payment, to look for the most efficient ways to provide high quality medicine, and to demonstrate that quality and value to purchasers. There will be adequate integration of the medical group, hospital, pharmacy, and ancillary services to permit the close collaboration necessary for CQI to work. Whether the organization needs to be
Some cautions about the prepaid group practice model

The integrated, multispecialty group practice model has, as we have seen, many advantages. However, we must also point out some potential disadvantages of this practice model, compared with the traditional small practice, or an IPA-style HMO. Modern medical care tends to be complex and technical, requiring a complex organization and specialization of labor both among physicians and among ancillary personnel. For an ill patient, this complexity can become a nightmare. A patient in a large group practice HMO might call the doctor’s telephone number, be put into an incomprehensible automated telephone answering system, or reach a ‘call center’ hundreds of miles away, and speak with a nurse who has never seen the patient’s physician, much less the patient. The physician might not have the same sense of personal responsibility for the patient’s care that one in private practice might have; perhaps the physician joined the group precisely because it offers a ‘lifestyle’ with predictable hours.

The well-coordinated efforts of the large group to develop evidence-based protocols for hospital care or treatment of chronic diseases might succeed in reducing variation, and might in some cases result in better health outcomes at lower cost. But if protocols are followed thoughtlessly, or adhered to out of fear of a lower performance measurement score, then errors will surely occur that will result in harm to patients. Other problems occur because physicians are salaried. Decisions on physician salary are made on an administrative basis, rather than on the basis of services provided. While this is good on the whole, there will always be perceptions of unfairness in setting pay, and jealousy between physicians who think some of their colleagues are not working as hard. Administrative duties, for example, may be either in perception or reality a way of getting out of seeing patients.

How do we deal with these and other potential weaknesses of the large group practice? First of all, by recognizing that there is no perfect organization, and no perfect medical practice. Secondly, by recruiting the best, most qualified and most caring physicians into the group. Solo practices’ losses are now group practices’ gains, as entry into a large group is now seen as an advantage, rather than as a position lower in prestige, as it often was in the past.

The best guarantee against a large prepaid group practice becoming too rigid and bureaucratic is the active competition of the marketplace. The bureaucratic barriers to access in group practice HMOs (long waiting times to appointments, etc.) are being overcome to a large degree, in order to avoid loss of membership. Such changes would not be occurring in the absence of a serious threat to the survival of these organizations, from competitors that had succeeded in overcoming the group practice HMO’s previous advantage in lower hospital utilization.

Fortunately, the model of capitated payment to the large medical group, together with the existence of a wide variety of expertise within the organization, provides the flexibility to adopt highly innovative modes of practice, where they can be shown to provide advantages in cost or quality. If a lipid patient can be managed by a nurse, contacting the patient by telephone rather than requiring an office visit (because that’s what the insurance reimburses), and if the patients are happy with this (as they are) then money has been saved which can be put to better use. If hospitalization for asthma can be reduced through a patient education program that encourages use of a peak flow meter, the entire organization profits from the reduced hospital costs. Capitation and integration, therefore, provide the incentives and the organizational structure to adopt whatever practice mode is most effective. The control of medical practice and medical decision-making is retained by physicians. These physicians work as colleagues in an environment that encourages cost-consciousness, but refrains from taking a physician to task for any individual patient care decision.

It is sad that traditional solo and small practice is becoming less and less viable, for this means less choice for both physicians and patients. But in today’s health care setting, in which large for-profit health plans are more and more in control of health care, the only realistic way for physicians to regain and retain the primacy of the physician in health care is by organizing themselves into large groups that have a better chance of survival in today’s highly competitive health care market.

Conclusion

The development of managed care in the USA has reflected partly the response to the health care system that was in place when HMOs first were formed. Although the largest and one of the oldest group plans, Kaiser Permanente, was the model for the Nixon administration’s HMO Act of 1973, it was instead the IPA model that became much more popular. This was due to the reluctance of the public to give up the personal physicians they felt comfortable with in favor of a large, anonymous medical group, and to the reluctance of
physicians to give up their solo or small practices. Now, however, circumstances are changing. HMOs have made continuity of care more difficult with the easy termination of physicians’ contracts. Solo and small practice is disappearing as a viable option for most physicians. In response to a number of pressures, physicians are consolidating into groups. Whereas until recently physicians were at a disadvantage in negotiating with a large HMO, they have the capability of improving their negotiating leverage by forming larger groups. Having already assumed, through capitated payment, the risk that was assumed in the past by an insurance company, the medical group as the core of a new managed care organization is in a position to regain for physicians the role which only they can properly fulfill as managers of the health care system. The result can be not managed care, but physician-managed care.

**Author's interests**

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